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School of Health and Social Sciences

"Working in partnership to support the women"

The Stella Project Mental Health Initiative

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Contents

Glossary

Organisations

ARA	Addiction Recovery Agency (Bristol – Substance Misuse Service)
AVA	Against Violence and Abuse
BDP	Bristol Drugs Project (Bristol – Substance Misuse Service)
BHT	Bristol NHS Trust
CAMHT	Community Adult Mental Health Team (Hounslow – Mental Health Service)
CAMHS	Community Adult Mental Health Service (Hounslow – Mental Health Service)
CAT	Community Alcohol Team (Nottingham – Substance Misuse Service)
CRI	Crime Reduction Initiatives (Hounslow – Substance Misuse Service)
CRP	Crime Reduction Partnership (Bristol – Substance Misuse Service)
CST	Community Safety Team Hounslow
EACH	Ethnic Alcohol Counselling in Hounslow (Hounslow – Substance Misuse Service)
FPS	Forensic Psychological Services
GCMHT	Gedling Community Mental Health Team (Nottingham – Mental Health Service)
NCC	Nottingham City Council
NHT	Nottinghamshire Healthcare NHS Trust
NL	Next Link (Bristol – Violence Against Women Service)
OC	Oxford Corner (Nottingham – Substance Misuse Service)
RC	Rape Crisis (Nottingham – Violence Against Women Service)
R	Refuge (Hounslow – Violence Against Women Service)
RE2	Redwood 2 (Nottingham – Mental Health Service)
RO2	Rowan 2 (Nottingham – Mental Health Service)
SPMHI	Stella Project Mental Health Initiative
SS	Second Step (Bristol – Mental Health Service)
TGH	The Green House (Bristol – Mental Health Service)
VS	Victim Support (Hounslow – Violence Against Women Service)
WISH	WISH for a Brighter Future (Bristol – Violence Against Women Service)

WLMHT	West London Mental Health NHS Trust

Terms used in the evaluation

DV	Domestic Violence
MH	Mental Health
SV	Sexual Violence
SPMHIC	Stella Project Mental Health Initiative Coordinator (Jennifer Holly)
SU	Substance Use
VAW	Violence Against Women

Background

Services commissioned to support women with mental health problems, problematic substance use and experiences of domestic and sexual violence often work in isolation, despite the intersectionality of these issues. Frontline practitioners do not always have the training, assessment tools and referral pathways to address all three issues when they occur. Operational and monitoring frameworks do not always make the links between the issues which result in women falling through the gaps in service provision. The aim of the Stella Project Mental Health Initiative (SPMHI), therefore, is to empower services across the three sectors of substance use, mental health and violence against women to develop this work through knowledge transfer, policy development support and promoting strong partnerships and monitoring mechanisms. In assessing the efficacy of the SPMHI, an evaluation was commissioned which will collect data before and after the intervention takes place. Before we consider the scope and findings of that evaluation, it is necessary to first outline the nature of the SPMHI. There are several components, encompassing an action research based intervention, practice guidance development and the creation of online learning tools:

- **Policy and procedure development, training and partnership working.** The SPMHI will work with selected agencies working in the fields of violence against women, substance use and mental health in three regions of the UK to develop an integrated response to survivors of gender based violence and who are experiencing problematic substance use and psychological distress. This will focus on providing:
    - Support to agencies to develop their policies and procedures (including risk assessments and care plans), referral pathways and multi-sector partnerships
    - Training to equip staff with skills and confidence to work with the complex issues and;
    - Support to embed issues in local authority and PCT strategic policies.

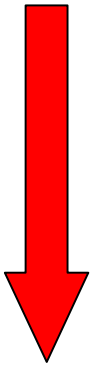
- **Good practice guidance.** Following completion of the action research, good practice guidance will be developed and widely disseminated across the UK through our

extensive networks. We also propose to run a series of inter-active and innovative workshops which focus on equipping practitioners with the skills and understanding to implement the good practice guidance.

- **Online training course**. A web-based interactive training course will be developed to address the overlapping issues. This could be accessed by any practitioner across the UK for free.

The Stella Project selected three sites across the United Kingdom: Bristol, Nottinghamshire and the London Borough of Hounslow in the summer of 2010. Frontline agencies were invited to submit expressions of interest to the identified strategic leads in their site, who were responsible for selecting participating agencies (a total of seventeen agencies (who together provide a total of twenty services) across the three sites). The selection was based on the capacity and commitment of each agency to engage with the work. This work is fully funded by a three-year grant from the Department of Health. The timeline for the intervention and evaluation is shown in Box 1 below.

BOX 1 - TIMELINE FOR THE INTERVENTION AND EVALUATION



October 2010 – March 2011	Design materials, obtain ethics approvals.
April – June 2011	Pre-intervention data collection
July 2011	Intervention begins
March – May 2012	Mid-point interviews with agency leads
May 2012	Interim report
June – September 2012	Finalise materials for post-intervention data collection.
September 2012	Intervention ends
October – December 2012	Post-intervention data collection
March 2013	Final report
May 2013	End of project presentations

Objectives of the Evaluation

The evaluation has six objectives. The first will be addressed at the outset of the evaluation and the remaining five will be addressed during both stages of our evaluation 1) pre-intervention (April-July 2011) and 2) post-intervention (October – December 2012). The objectives are:

1) To compare alternative approaches made elsewhere with those taken within Stella and to highlight lessons learnt within them. This archival component of the research is desk based and takes the form of a comprehensive literature review including grey literature, academic and policy documents.

2) To assess expectations, for the project, of the project co-ordinator and ascertain what contingencies are in place. Expectations of and for a project can be highly influential in its eventual outcomes. Also, expectations can provide another way to assess levels of shared understanding that feed into partnership working (see 3 below).

3) Does staff confidence in their own knowledge and skills change over the course of the evaluation? Here, we focus on staff confidence in their own knowledge and skills required to address the overlapping issues and to respond appropriately to disclosures made by service users, both directly and as part of referral. We also seek to explore the level, quality and nature of such confidence.

4) What are the levels of multidisciplinary partnership working, referrals and joint care planning between agencies over the course of the evaluation?

5) What is the level of monitoring service users disclosing experiences of domestic and sexual violence, substance use and mental distress (understood here to mean recording of and provision of support/referrals in light of) over the course of the evaluation?

6) To what extent are AVA's priorities a feature in local service strategies and within strategic needs assessments (alcohol, VAW, drug treatment plans, homelessness) over the course of the evaluation?

Method

The research design is a triangulated, mixed methods approach, drawing on both prospective and retrospective research techniques. There were considerable concerns about the use of the terms 'Domestic Violence (DV)', 'Sexual Violence (SV)' and 'Violence Against Women (VAW)' which we discussed at length with the SPMHIC and the steering committee. It was agreed that the term VAW would be used because many women who experience DV will also experience SV and the splitting of DV and SV is a historical legacy from third sector devolution, but does not reflect real life. In order to ensure that we check practitioners understanding of the term VAW we built a question into the survey which asked them to define it. However because much of the research and evaluation in this area still uses the terms DV and SV we used those terms in the literature review to ensure we captured all the relevant information.

Literature Review (Objective 1)

A question led adapted Rapid Evidence Assessment (REA) has been conducted as resourcing limitations (time and labour) prohibited the undertaking of a systematic review of the literature. An REA is a tool for synthesising the available research evidence on a policy issue, as comprehensively as possible, within the constraints of a given timetable. A toolkit for undertaking an REA has been widely implemented since its inception by Government Social Research (see http://www.gsr.gov.uk/professional_guidance/rea_toolkit/sitemap.asp also recently used by Brown, Horvath, Kelly & Westmarland, 2010). The terms of the REA, and the key terminology adopted, were formulated in consultation with AVA. Two overarching questions led the REA:

1. What integrated responses to any combination of two or more of the following issues: sexual violence (SV); domestic violence (DV); substance use (SU) and mental health (MH) exist? Have they been evaluated and if so what were the outcomes?
2. What is considered best practice for practitioners working with women with the overlapping issues of sexual violence, domestic violence, substance use and mental health?

Five specific questions provided a more detailed structure for the REA:

- Do integrated responses to the combination of two or more of the issues of SV, DV, SU & MH exist? If yes, what are they and what are their success rates?
- How effective are interventions that aim to improve the delivery of services to women experiencing DV, SV, SU and MH through partnership working or integration/coordination mechanisms at producing improved outcomes?
- What makes an intervention based on integration mechanisms effective? Do integrated responses achieve improved outcomes?
- What is best practice for frontline practitioners working with women with overlapping needs?
- What is best practice for strategically linking work with women with overlapping needs? NB, the focus here is not on frontline practitioners, but those with strategic, policy responsibilities.

In order to find literature for the RAE we restricted the search to the last 15 years (1995-2010). To find academic literature 13 search engines were used (see Appendix 1 for the full list). To find grey literature, we used the following search portals/approaches:

- http://opensigle.inist.fr/
- http://www.nationalschool.gov.uk/policyhub/
- evaluation team members and the SPMHIC sent requests to their extended networks of researchers and practitioners requesting relevant material;
- current holdings by researchers and AVA were drawn on;
- web searches were conducted through Google (and GoogleScholar) using the same terms as the database searches and the first 50 hits from each search term investigated.

Assessment of Expectations (Objective 2)

One focus group was conducted in each of the three areas pre-intervention. Service and area leads were invited to take part. There were between five and eight participants in each focus

group. An invitation, information letter and consent form were sent out to participants in advance of the focus group (see Appendix 2). The focus groups were run according to the guide that was designed (see Appendix 3) this was used in conjunction with instructions for making an eco-gram (See Appendix 4).

Staff Confidence (Objective 3)

One online questionnaire was designed to address Objectives 3 and 5 (contact the authors for a copy). The questionnaire covered three main topics: Staff Confidence; Staff Knowledge and Data Monitoring. Service leads were e-mailed by the evaluation team briefing them about the questionnaire and asking them to invite all of their staff to complete the questionnaire online (a link to the website hosting the questionnaire was provided). The service leads forwarded the email to all staff and staff completed the survey during an 8 week period (11th April 2011 – 3rd June 2011) prior to the initial intervention.

Partnership working (Objective 4)

Two strategies were employed to address objective 4. Strategy 1 involves a database of monthly referrals for each service (see Appendix 6 for the variables included in the database). We originally proposed that data should be collected prospectively on a monthly basis from the start of the project until the post-intervention stage from existing agency records. However, it became apparent that given all of the demands on the services involved and the SMHIC that this was not feasible. The SPMHIC proposed a series of alternatives to the service leads at working group meetings in July 2011. It was agreed that the following strategy would be used. Instead of prospective data collection of the life of the project, retrospective data collection for a four month period of each year of the project is being used. Each agency is completing a spreadsheet giving information about signpostings/referrals which followed disclosures of domestic and sexual violence and/or substance use and mental health problems that were made between January 1st and April 31st for each year of the project. Therefore there will be three waves of data collection for this element of the evaluation.

Strategy 2 is being conducted twice (pre and post intervention) and is a desk based document analysis of all documentation relating to partnership working, referrals and joint care planning with other agencies. The ecograms completed in Objective 2 provide representations of partnership working, referrals and joint care planning will also be used to provide extra information for strategy 2.

Monitoring Data (Objective 5)

See objectives 3 and 4.

Adoption of AVA/Stella Project priorities within the target services/areas (Objective 6)

A desk based document analysis of local strategies/strategic needs assessments which will be conducted at pre and post-intervention stages. To supplement the data collected for objectives 1-6 we will conduct mid-point telephone interviews with all agency leads from all three areas (see Appendix 7 for the invitation letter, consent form and interview schedule). These took place in March and April 2012.

Participants

Table 1 shows the services in each area of the country involved in the initiative. The number of members of staff the organisation expected to be participating in the initiative has a question mark after a figure if it is approximate.

Table 1. Services involved, their specialism and number of staff

Area	Organisation Specialism	Organisation Name	Number of staff
Bristol	Violence Against Women	Next Link	20
		WISH	5
	Mental Health	The Green House	5?
		Second Step	15?
	Substance Use	BDP	30
		ARA	25
Nottingham	Violence Against Women	WAIS	20?
		Rape Crisis	22
	Mental Health	Rowan	24
		Redwood	32
		Gedling	30
	Substance Use	Oxford Corner	15
		CAT	30
Hounslow	Violence Against Women	Victim Support	3
		Refuge	15
	Mental Health	CAMHT	34
		CAMHS	<30
	Substance Use	EACH	10?
		CRI	15

The service WISH in Bristol is shaded in red because they lost their funding in the summer of 2011 and therefore had to withdraw from the initiative. Before they withdrew, their staff had completed the staff survey and their data have been retained for that stage of the evaluation. Further details about who took part in each element of the evaluation are presented with the results for that section.

Literature Review

1) ***Do integrated responses to the combination of the intersecting issues of DV and/or SV <u>with</u> SU and/or MH exist? If yes, what are they and what are their success rates?***

Please note that here we exclude the combination of SU and MH in isolation ('dual diagnosis') as outwith the purview of the REA. Similarly, while we searched the literature for domestic violence <u>and</u> sexual violence most of the literature found relates to domestic violence, and little around sexual violence.

<u>BOX 2 - KEY FINDINGS FOR LITERATURE REVIEW QUESTION 1</u>

Sexual violence (SV), domestic violence (DV), substance use (SU), and mental health (MH) often co-occur (Alberta Council of Womens' Shelters [ACWS], 2009; Chang et al., 2010; Humphreys, Thiara & Regan, 2005; Moses, Reed, Mazelis & D'Ambrosio, 2003). However there exist very few programmes that deal with more than one of these issues concurrently. Integrated responses are more common in North America than in the United Kingdom, although existing evaluation data do not permit robust comparisons between integrated programmes and single issue programmes. Thus, the success of such programmes is difficult to assess empirically. However, the literature does suggest a number of positive outcomes from collaborative work in these areas. These include enhanced information sharing, collaborative case plans and improved client outcomes. Barriers to effective collaborative work include communication issues and lack of information sharing; lack of clearly defined roles; lack of a shared focus; and lack of resources.

There is plenty of evidence that sexual violence (SV), domestic violence (DV), substance use (SU), and mental health (MH) often co-occur (ACWS, 2009; Chang et al., 2010; Humphreys, Thiara & Regan, 2005; Moses, Reed, Mazelis & D'Ambrosio, 2003;) Further, as Zweig and colleagues (2002, p. 170) assert, "the problems that many women victims of violence face, such as housing or employment, are compounded and complicated by the other issues in their lives." The need for integrated service responses is increasingly recognised, with a consensus panel of domestic violence and substance use experts attesting that "failure to address domestic violence issues interferes with treatment effectiveness and contributes to relapse" (Center for Substance Abuse Treatment, 1997, p. 5). However, despite the recognition of the need for

integrated services responses for women survivors of violence with intersecting issues, there exist very few programmes that deal with more than one of these issues.

Integrated responses are more common in North America than in the United Kingdom, although existing evaluation data do not permit robust comparisons between such integrated programmes and single issue programmes. Thus the success of such programmes is difficult to assess empirically. However, the literature does suggest a number of positive outcomes from collaborative work in these areas. These include enhanced information sharing, collaborative case plans and improved client outcomes. Barriers to effective collaborative work include communication issues and lack of information sharing; lack of clearly defined roles; lack of a shared focus; and lack of resources.

There is some attempt in both the United States and Canada to facilitate better inter-agency co-operation for these overlapping issues, in different combinations. In a recent report on the need for integrated responses to meet the needs of women experiencing these intersecting issues, the Canadian Women's Foundation (2011, p. 23) reports "an encouraging and growing number of regional and provincial collaborative initiatives – whether training, education and services - from services providers, regional health providers and some ministries in some areas of the country." However, they also note that an investment of considerable resources and funding is necessary in order to develop, evaluate and sustain these collaborative initiatives.

Two key contemporary Canadian projects are currently seeking to provide a more robust foundation for collaborative work. The BC Society of Transition Houses (2011) is developing a more coordinated approach to services for women who have experienced domestic violence and who may also have mental health and substance use issues. They are currently piloting a programme that includes a toolkit and four day training programme for practitioners. The end product of the Reducing Barriers project will be a toolkit for agencies to use to adapt their policies, procedures and practices to more effectively serve the needs of women with these intersecting issues. The Woman Abuse Response Program (WARP) is currently undertaking a

widespread consultation to identify the extent to which services in British Columbia are able to work together to meet the needs of women who have experienced domestic violence and mental health or substance use problems. The consultation will inform systematic changes to "policy, funding and program planning for services that support women impacted by these three issues" (Canadian Women's Foundation, 2011).

Moses, et al., (2003) identifies a number of treatment plans that address at least two of the issues mentioned. One is called Seeking Safety; run as group or individual sessions by mental health and substance abuse clinicians to help individuals who are coping with PTSD (which may be a result of domestic violence) and problematic substance use to establish some safety in their lives (Moses, et al., 2003). Another is the Addictions and Trauma Recovery Model (ATRIUM), which is also a group programme that teaches about the problems related to trauma such as mental health issues and addiction. It also aims to teach women how trauma expresses itself in the body (Moses, et al., 2003). The Triad Women's Group is a cognitive-behavioural approach for women with substance abuse and mental health disorders who have experienced trauma. This group has multiple goals, which aim to help women find safety, prevent relapse, build supports and cope with distress (Moses, et al., 2003). These programmes have proved successful in America but our search of the literature did not identify any evaluations of similar programmes in the United Kingdom despite anecdotal evidence suggesting that local programmes may exist. This points to the importance of clearly documenting British programmes that address these intersecting issues.

Given that there are so few integrated intervention programmes it is difficult to provide a strong assessment of how successful they are. Moses, et al., (2003) discuss in their report the successes of the three projects they mentioned. An evaluation of the Seeking Safety programme found 'significant improvements in substance use, trauma related symptoms, suicide risk, suicidal thoughts, social adjustment, family functioning, problem solving, depression, cognitions about substance use, and didactic knowledge related to treatment' (Moses, et al., 2003, pg. 12). This study also found a sixty-three percent retention rate for the

program, which according to the author 'was higher than most other studies of substance abuse populations with comparable lengths of treatment' (Najavits, Weiss, Shaw & Muenz, 1998, pg. 451). The study also found improved therapeutic relationships for participating women and their therapists (Najavits, et al., 1998). Another evaluation found decreases in behaviours such as 'self-harm, substance abuse, suicidality and aggression' in women who completed the ATRIUM programme (Miller, 2002, pg. 161). Finally, the Triad Women's group resulted in 'an increase in adaptive coping skills and a decrease in avoidance behaviours associated with substance abuse and traumatized reactions. Women also experience a decrease in mental health symptoms' (Moses, et al., 2003, pg. 14). Unfortunately, none of these evaluations mention a control group, and Najavits and colleagues (1998) assert that the lack of control groups is a 'methodological flaw and renders all outcome results tentative' (pg. 453). This makes it difficult to compare the success of these integrated programs to other, single-issue programs in order to see if integrated responses really are better.

The literature on the benefits and challenges to establishing integrative work in these overlapping areas document both positive and negative outcomes. Darlington, Feeney and Rixon (2004) looked at a collaboration effort between mental health workers and child protection workers and found that 57.7% of the cases they looked at experienced positive outcomes from collaborative work. These results included 'improved client outcome' and working well together by sharing information and coming up with case plans (Darlington, et al., 2004, pg. 1185). However the research also identifies some barriers to collaborations such as communication issues, lack of information sharing, lack of clearly defined roles, differing focuses from the different workers, and not enough resources (Darlington, et al., 2004; Mastache, Mistral, Velleman & Templeton, 2008). One particularly problematic issue highlighted by 6, Bellamy, Raab and Warren (2006) is information sharing. They discuss the difficulties practitioners face when they are deciding what patient information to share with their team members and what they should keep confidential. There are conflicting ideas concerning confidentiality; there are rules that increase patient privacy such as the Code of Confidentiality but within the mental health profession, there are now greater demands for

sharing information (6, et al., 2006). An issue arises because practitioners 'are concerned about the possibility of being blamed either for sharing or not sharing when decisions turn out to lead to unwelcome outcomes' (6, et al., 2006, pg. 240). The research suggests that successful information sharing is key to any effective multi-agency collaboration effort but to achieve this, agencies must adopt processes to share relevant information while still protecting their patient's confidentiality.

There is considerable evidence available to explain why effective integrated responses are not common. According to Humphreys, Thiara and Regan (2005) it can be difficult for specialists from different backgrounds to work together because various disciplines have different philosophies (also see BC Society of Transition Houses, 2011). For example, it may be common that services for victims of domestic and sexual violence take a feminist approach that aims to empower survivors whereas substance use and mental health services often work from a gender-neutral perspective (BC Society of Transition Houses, 2011; Humphreys, et al., 2005). There can also be disagreements between disciplines about which issue to prioritise and the aetiology of co-occuring problems (Humphreys, et al., 2005), which can raise the question of which issue to treat first (Zubretsky, 2002). Substance abuse programmes tend to centre around the substance use issue first but from a domestic violence support perspective increasing the survivor's safety is prioritized (Zubretsky, 2002) though some domestic violence services, particularly refuges, may prefer that substance use issues be addressed prior to accepting women (Zweig et al., 2002). Women also might rely on substances to help them cope with their lives in the face of danger, continuing to use them whilst exiting a violent situation (Zubretsky, 2002). Taken together, these findings seem to reflect a belief from both services and individual practitioners about 'treatment' having to be serial, dealing with one 'problem' at a time depending on the 'need' and/or 'risk', which itself may be creating a further barrier to successful integrated response programmes.

Zweig and colleagues (2002, p. 175) report a series of further barriers that may prevent agencies from effective integrated working with women who have experienced sexual or

domestic violence and who also have substance use or mental health issues. The agencies perceived by their respondents as representing 'the weakest links', in terms of successful interagency working, included criminal justice system agencies, health agencies, social services, mental health and substance abuse services. Specific barriers included such agencies being "insensitive to, incapable of communicating with, or biased against women with multiple barriers… being insensitive to victims in general and … not tak(ing) domestic violence and/or sexual assault seriously… not implement(ing) the policies that it has agreed to implement and not practic(ing) what it has promised… not car(ing) to change to address violence against women… (being) a bureaucracy with too much red tape; agenc(ies) want(ing) to serve "ideal" victims, not victims who are struggling with other concerns in addition to the violence; and … agenc(ies being) insensitive to victims' need for safety… lack of training for agency staff and lack of trust between agencies."

Another concern evident in the literature about integrated services, is related to a perceived lack of knowledge about the overlapping issues among practitioners; many report that they do not feel comfortable addressing an issue in which they are not trained (Humphreys, et al., 2005). Finally, there are funding and resource problems. It can be hard to get funding across specialties and then to maintain that funding in the future (BC Society of Transition Houses, 2011). It can also be difficult because different agencies do not have the resources to address more than one issue (Humphreys, et al., 2005). In a report released by the Stella Project, these resources may include 'funding, time, skilled staff and knowledge' (Carter, 2003, pg. 10).

This long list of barriers prevents agencies from creating effective integrated response programmes.

2) ***What makes an intervention based on integration mechanisms effective? Do integrated responses achieve improved outcomes?***

BOX 3 - KEY FINDINGS – LITERATURE REVIEW QUESTION 2

There is a considerable body of research that provides suggestions for the best way to achieve optimal collaboration and integrated responses. These include the development of a shared vision and the establishment of a shared set of key terms to encourage communication across different areas of practice. Joint training across services, the inclusion of service users in multi-agency training sessions, and regular multi-agency meetings have been identified as key practices for the development of effective integrated response teams. However, it should be noted that these suggestions are grounded in a limited set of observations made by researchers concerned with the relative lack of effective integrated responses.

There has been some research into reasons why there are so few successful integrated response programmes. Such research usually concludes with suggestions for how to implement a programme which effectively combines professionals from different fields. They include steps to follow to bring different agencies together in a successful collaboration, which involve ways to communicate effectively as well as ways to learn about other fields. There are commonalities between the suggestions provided by different research teams however there has not been any systematic empirical research done to look at how effective these suggestions are in practice. This highlights the need for further work in this area. The SPMHI represents a British intervention that will go some way towards filling this gap in the literature.

There is a considerable body of research that provides suggestions for the best way to achieve optimal collaboration and integrated responses (Cowley, Bliss, Matthew & McVey, 2002; Dion, 2004; Mackie & Morton, 2001; Moses, et al., 2003; Moses, Huntington & D'Ambrosio, 2004). One of the first steps to creating a successful collaboration has been argued to be the development of a shared vision that all parties involved can agree on and that is interpreted the same way (Dion, 2004; Mackie & Morton, 2001; Moses, et al., 2003; Moses, et al., 2004). Next it has been proposed that the team must come up with shared meanings for terms so they can talk, listen and understand across disciplines (Caldwell & Atwal, 2003; Dion, 2004; Mackie &

Morton, 2001; Moses, et al., 2003). Different disciplines may use the same word to describe different contexts; for example 'comprehensive assessment' which has slight variations in meaning depending on the agency (Mackie & Morton, 2001).

Joint training involving individuals from the different agencies has also been suggested as a beneficial way to encourage people to meet each other as well as to teach them about fields that are not their primary specialism (Humphreys, et al., 2005; Moses, et al., 2003; Moses, et al., 2004), as has meaningful user engagement (Moses, et al., 2003). To keep the communication between the agencies frequent and functional, it is necessary to have meetings on a regular basis that involve representatives from the different agencies who can discuss their roles in the treatments (Cowley, et al., 2002; Mackie & Morton, 2001; Moses, et al., 2003). These steps combined have been argued to lead to the creation of an effective integrated response team based on observations of successfully integrated systems made by a few research teams (Cowley, et al., 2002; Mackie & Morton, 2001; Moses, et al., 2003). It should be noted however that these suggestions come from observations by researchers who are looking at why there are so few integrated responses. There is no follow up research to show that these suggestions will lead to a successful integrated team, so it is important to use caution when following them.

3) *What is best practice for frontline practitioners working with women with overlapping needs?*

BOX 4 - KEY FINDINGS – LITERATURE REVIEW QUESTION 3

There is a paucity of research on identifying best practice for women with overlapping issues. This is in part a likely consequence of the primary presenting issue being treated, in practice, as singular – or as masking other intersecting issues. The bulk of the existing literature on best practice for frontline practitioners working with women with overlapping needs has a focus on the needs of women initially presenting with domestic violence and comes out of the DV/women's sector. This literature emphasizes, firstly, the importance of establishing women's safety; adopting a 'woman centered response' where the woman is treated as the expert in knowing what she needs; and identifying any overlapping issues, with an emphasis on routine enquiry, as well as finding appropriate responses that address them. Ideally, practitioners should have some comfort in addressing a range of intersecting issues even if they are not 'professionals' in each of those fields. Women's Aid (2005) further recommends that practitioners are trained to carefully document any disclosure of abuse so that if necessary, this can be used in court, though practitioners may be reluctant to document other intersecting issues, as these may potentially be used against women in court.

Very little research has been done to identify best practice for women with the overlapping issues of abuse, problematic substance use and mental health issues. There are, however, several resources that offer some recommendations for working with women who have a history of domestic violence. There are also some domestic violence services for female survivors that have addressed the issue of best practice when working with women with overlapping needs. These include suggestions generic to survivors of domestic violence that are also applicable to women with multiple needs. They include listening to the woman as well as documenting abuse in case the woman plans to bring it to court. The literature emphasises the woman's abuse as the more important issue to address in order to make sure she is safe.

A major recommendation for best practice for any woman who is experiencing domestic violence is to establish safety for her (ACWS, 2009; BC Society of Transition Houses, 2011; Hein & Ruglass, 2009; Women's Aid, 2005). This can be done by empowering women to take control of their lives and by helping them find safe spaces and relationships (Hein & Ruglass, 2009). It

can also be useful for the woman if a safety plan is established that allows her to find safety when there is some threat of abuse (ACWS, 2009). A positive and trusting relationship with medical providers (Barry, 2007) is also a key factor, especially if women are going to feel comfortable enough to disclose matters such as domestic violence (Bauer & Rodriguez, 1995).

However, the Stella Project (2005) stresses that if services do not identify and address drug and alcohol issues, women experiencing violence may be placed at greater risk of harm, due to the impact of these intersecting issues on multiple aspects of their lives, including their capacity to access safe spaces, their experience of the criminal justice system and their anxiety about the security of their custody of their children. It should be noted that some practitioners may be wary of recording and reporting multiple issues, as they are aware that these may be 'used' by perpetrators, and their legal counsel, against women. For instance, Zweig and colleagues (2002) report that, "batterers use the problems women experience (e.g., substance abuse) as abuse strategies (e.g., supplying alcohol or drugs, not allowing women to take medication for mental health issues)."

The BC Society of Transition Houses (2011) offers several suggestions for best practice when working with women who present more than one issue. These include, providing a woman centred response where the woman is treated as the expert in knowing what she needs, ensuring that patients are not 'oppressed' further, and recognising the overlapping issues as well as finding a response that effectively addresses them. The practitioner should have some comfort in addressing all of the issues even if he or she is not a professional in each of those fields, and should focus on ensuring the woman's safety so she can reduce stress and hopefully recover more successfully.

The British Columbia Centre of Excellence for Women's Health (2004) assert that women accessing domestic violence refuges may be at a stage of readiness to address both their experiences of violence and their substance use issues. They found that "women's substance use decreased after their shelter stays both in shelters that offered brief interventions and

those that offered more substantive interventions"(p. 11). Importantly, these interventions were not just drug and alcohol focused, but were provided in the broader context of attempts to assist women to 'restructure their lives' within an environment where they felt 'safe' to disclose and discuss other issues.

Women's Aid (2005) highlight some other important practices for service providers who work with women with overlapping needs. They include being sure to believe a woman who says she was abused, carefully documenting any disclosure of abuse so that if necessary, it can be used in the courts later on and making sure to offer the woman several options for what steps to take in case she is not ready to leave her partner. Hein and Ruglass (2009) also recommend that practitioners be aware of the legal options that may be available to their patients in case they wish to use legal remedies.

However, the Stella Project (2003) notes that women with substance misuse problems may have a high level of distrust of agencies and a high level of anxiety about coming into contact with the criminal justice system. This may be exacerbated if the woman has children, or if she is involved in illegal activities. Thus women with these intersecting issues may respond initially with anxiety and mistrust to frontline workers when presented with 'legal options' that involve 'going to court'. The Stella Project also report that women who are experiencing domestic violence and substance use issues may have had negative encounters with service providers, ranging from feeling 'ignored' to being actively discriminated against. Thus, this stigmatised client group may be particularly vulnerable to feelings of alienation, shame and stigma and may be difficult to engage. The Stella Project recommends that frontline workers be aware of the negative stereotypes they, and workers from other sections, may hold about women with these intersecting issues and that services develop ways of engaging with, and positively screening, so as not to alienate these women further.

4) ***What is best practice for strategically linking work with women with overlapping needs, i.e. not frontline practitioners?***

BOX 5 - KEY FINDINGS – LITERATURE REVIEW QUESTION 4

Best practice for the strategic development of work with women with overlapping needs aims to address the barriers to effective integrated responses (above) with a focus on communication and training. Improved communication between agencies may involve adjusting confidentiality requirements or creating protocols for addressing women who present with overlapping needs. These protocols should encourage multiple agencies to work together and to share information, when appropriate. Other measures may include establishing the opportunity for regular networking between agencies, via the creation of a multi-agency forum. Also recommended is the implementation of routine questioning to screen for domestic violence in women when they first present to a service in order to encourage disclosure; and ensuring that there is at least one staff member specifically tasked with addressing domestic violence issues when they arise. Screening for MH/PSU is often overlooked. Involving women who have survived these intersecting issues in the policy planning and implementing process is also recommended.

Best practice for strategic development of work with women with overlapping needs is mostly presented in the form of policy suggestions for organisations (BC Society of Transition Houses, 2011; Darlington & Feeney, 2008; Women's Aid, 2005). These policy suggestions address some of the barriers to effective integrated responses that were presented earlier. They deal primarily with communication and training concerns. It is important to note that many of these policy suggestions may be applied to best practice for multi-agency programmes more generally and not just for programmes that address women with overlapping needs. However, recommendations specific to agencies that work with women with overlapping needs are also presented.

Darlington and Feeney (2008) conducted a study of professionals in the mental health and child services disciplines and found that workers wanted to see improved communication between agencies, which would involve changing the confidentiality requirements as well as creating protocols that force multiple agencies to work together. Their subjects also expressed a desire

for training programmes for the workers so they could know more about the different issues they might encounter. The workers in the Darlington and Feeney study also expressed concern about the inadequate resources their agencies were receiving, the need for more workers to fill existing caseloads, and better facilities. Some recommendations for how to address these problems can be found in an article by Secker and Hill (2001) who saw similar issues arising in a study of workers from 30 different agencies that deal with issues such as drug and alcohol use, criminal justice, housing, and mental health. They suggest the development of training packages to provide to the various agencies as well as a detailed protocol list that would cover what information should be shared. In order to make sure the protocol is being followed and to allow a place for networking between agencies, they suggest a forum comprised of members from the various agencies (Secker & Hill, 2001).

In terms of addressing the needs of domestic violence survivors, the Stella Project (2003) and subsequently, Women's Aid (2005) offers some policy suggestions for services that work with women with overlapping needs. These include developing specific protocols in the organization to address women who present overlapping needs and holding regular training sessions for substance misuse and mental health staff so they can be aware of domestic violence issues, and vice versa. They stress the importance of being sure that their services are available to women of all cultural backgrounds (this applies to all victim-survivors whether they have overlapping needs or not). It is also considered essential to create and implement routine questioning to screen for domestic violence in women when they first come to the service in order to encourage disclosure, even if the woman was not planning to do so. There is a further recommendation that agencies which do not deal exclusively or primarily with domestic violence ensure that there is a member of staff who is in charge of domestic violence cases when they arise. Other studies also suggest involving women who have survived some of these issues in the policy planning and implementing process because they offer a unique perspective on the issues and their presence can empower the women who are taking part in the programs (BC Society of Transition Houses, 2011; Moses, et al., 2003).

This REA has highlighted a relative lack of literature that addresses the specific needs of sexual violence survivors. Zweig and colleagues (2002) report that sexual assault victims may be especially reluctant to access victim services if they also had experienced substance abuse problems, which may further contribute to this gap in the literature.

Pre-Intervention Findings (Objectives 2-6)

Assessment of Expectations

One focus group was conducted in each of the three areas, pre-intervention. Service and area leads were invited to take part. In Bristol, seven members participated in the focus group, representing BHT; BDP; CRP; WISH; NL; TGH; and ARA. In Hounslow, five members participated in the focus group, representing CST; EACH; R; WLMHT; and CRI. In Nottingham eight members participated in the focus group, representing RE2; CAT; OC; NHT; RC; and NCC. A thematic analysis was conducted on each of the transcribed focus group discussions. The results are presented in brief, by area, below, showing the major themes each group raised regarding their expectations for the project.

The expectations of the focus groups from each of the three areas fell into three interlinked themes; these were: partnership working; building staff skills, knowledge and confidence; and benefits to service users. These expectations closely map on to the information provided to the participating agencies by the Stella Project (Holly, 2011, pg. 2). This set forth the project's aims to develop effective integrated responses to women experiencing domestic and sexual violence, problematic substance use and mental ill-health through "policy and procedure development, training and partnership working."

Partnership working

Hounslow participants' expectations centred around their hope that they would gain "a better understanding of what is out there" and "the types of services available." Some members expressed a sense of "work[ing] in silos and not know[ing] what other agencies are doing."

Others reported “internally working on these issues” but still wishing to “get a sense of what other agencies are doing.” Hounslow focus group members also expressed the expectation that the project would enable them to work in a coordinated fashion with other relevant agencies, or as one participant put it, “working holistically together” in order to “better engage our service users.”

The Bristol focus group also held the expectation that the project would enable them to enhance their partnership working and networking with other agencies, and to engage in “joint thinking.” As one participant explained, she anticipated “improved links with other agencies, which has already happened just by sitting round the table and putting names to faces.” The Bristol group also expected to strengthen existing ‘informal links’, and to create more ‘formalised pathways’ so that there would not be the need to rely on “old relationships”.

The Nottingham focus group reported their expectation that the project would help them to “work together to engage with clients and other agencies.” They also expected to improve their knowledge of potential referral pathways, “what’s out there, who and how to refer to.” Some participants were keen to build on ‘weaker relationships’ and to forge new links with ‘other vulnerable groups “such as equalities groups and male victims.”

Building staff skills, knowledge and confidence

The Hounslow focus group also held the expectation that the project would enhance the skills and confidence of workers within their agencies. Lack of confidence in assisting women with these intersecting issues was identified as a key barrier in the REA. One participant asserted that she expected the project would “Skill my workers to be confident enough to deal with issues that are not just related to substance misuse, so that they have their skills and information of where to refer these clients.”

The Bristol group also expected “to develop some shared understanding of what good practice is... what the Stella Project is doing, with the training and the policies.” They expected to

engage in further training, particularly around domestic violence, and to be able to "cascade [this] information down to staff." There was also an expectation that staff confidence and knowledge, and "capacity to know how to respond to the overlapping needs" would improve and "become part of organizational culture." They also anticipated being able to build on their knowledge base by sharing information, "e.g. what is available for the women with complex needs."

The Nottingham focus group also expected to develop an increased level of staff awareness, confidence and knowledge regarding identifying and responding effectively to the overlapping issues. One participant stated simply that they anticipated gaining the "Confidence to know what to do." Others asserted that they expected to develop skills, through training, in "knowing what to look for." Other participants reported an expectation that they would be able to "look at the strategic view and embed it in practice."

Benefits to service users

The Hounslow focus group expected that the project would be of benefit to their services' users. They expressed the expectation that the project would enable them to better assess and assist their clients, by raising knowledge and skills of their staff, by encouraging them not to "think in isolation in terms of the client", and by learning to "incorporate these skills in assessment and routinely ask these questions".

The Bristol focus group also asserted that they anticipated that the project would result in "improved outcomes for our services users", and "better pathways for patients" and, "to get a consistent approach and response for women." One participant reported her existing frustrations and her future hopes: "I have actually had people come to me with a client who they have been unable to place in a domestic abuse agency because of their substance misuse, so I would like to see that disappear."

The Nottingham focus group also reported that they anticipated that there would be benefits for service users. Some reported that they anticipating becoming better able to "best support clients", to "know what to look for" and to "respond more sensitively" especially in cases where "clients won't speak openly about domestic violence."

Staff Confidence

An online questionnaire was employed to address this objective. The questionnaire covered three main topics: Staff Confidence; Staff Knowledge and Data Monitoring. One hundred and thirty-nine staff attempted to fill in the questionnaire however two of the participants did not give their consent, so their data had to be removed. The remaining data were then analysed to identify whether any of the participants had not answered a significant number of the questions, 34 had left more than 50% of the questions unanswered, however only those who had left more than 90% unanswered were excluded from the sample (as they could effectively be deemed to not have filled in the questionnaire), in total 25 were excluded. The final sample for analysis was 112. The proportion of staff from each area completing the questionnaire was 36 (32.2%) from Bristol, 45 (40.2%) from Nottingham and 31 (27.6%) from Hounslow. A more detailed breakdown of the participants across the organisations can be seen in Table 2, which highlights the percentage of staff from each type of organisation that completed the questionnaire and that overall 29% of the staff invited to participate did, which is comparable with other evaluations using online staff surveys which have found wide variation in completion rates (for example Coy, Thiara & Kelly, 2011; Coy, Lee, Kelly & Roach, 2010).

Table 2. Distribution of staff completing the questionnaire according to area and organisation specialism

		Number of staff who completed the questionnaire	*Number of Staff invited*	*% of Staff completing questionnaire*
Bristol	Violence Against Women	6	25	24
	Mental Health	4	20	20
	Substance Use	26	55	47
Nottingham	Violence Against Women	17	42	40
	Mental Health	20	86	23
	Substance Use	8	45	18
Hounslow	Violence Against Women	17	18	94
	Mental Health	11	64	17
	Substance Use	3	25	12%
TOTAL		**112**	**380**	**29%**

Descriptive statistics for staff confidence and knowledge questions was conducted initially across all participants, then by area of the country and then by organisation specialism (the findings have been sent to the SPMHIC to inform her work but are too detailed for inclusion in this report). At the pre-intervention stage, time and data constraints did not permit the running of inferential statistics, therefore we cannot say for certain where differences exist. However in the paragraphs that follow we provide a descriptive account of the data highlighting some emerging areas of interest which will be explored in the final report with the post-intervention data and should be the focus of the SPMIHC's work for the remainder of the intervention.

The survey asked staff to "please provide a brief definition of Violence Against Women as you understand it". In practice, many respondents interpreted this request to be asking for a definition of domestic violence, e.g., "Domestic violence is the physical, sexual, emotional, mental, economic and social abuse and control of women by intimate or formerly intimate partners" (VAW worker, Hounslow). However, some staff provided definitions that emphasized gender and/or physical violence, e.g., "Any physical abuse of a woman by a man" (SU worker,

Bristol). To clarify matters, future surveys should be mindful of the impact of using terminology that not all practitioners are familiar with.

Initially staff were asked about what types of training they had received about VAW, SM and MH issues, from a range of six different types of training (including watching a video, a web-based programme, attending a lecture or talk, skills based training or other training lasting more than four hours). The number of different types of training staff had received about each topic was then calculated and summarised. Staff from each area had received the most types of training for topic that their organisation specialises in (see Appendix 1 for Figures 1.1-1.3 that summarise the types of training received). Across all agencies in all areas less than ten percent of staff had received no training on each issue (VAW=9[8%]; MH=4[3.6%]; SU=8[7.1%]).

Having established how many different types of training staff had received about each of the key issues, we explored their perceptions about how much training they had received and how confident they felt talking about each issue. It should be noted that the amount of different types of training staff had received is not the same as the quality or specificity of that training, time constraints mean it was not possible to interrogate this further in the questionnaire. Generally staff from all three areas reported having had the right amount of training and felt high levels of confidence talking about the topic their organisation specialised in. However the relationships between perception of amount of training and confidence for topics outside the organisations specialism appear to be more complicated with many staff in all areas reporting that they had not had enough training on such topics but that they felt medium or high levels of confidence talking about the issue (see Appendix 2, Tables 2.1-2.3). This mismatch between perception of amount of training and confidence talking about a topic requires further investigation and will be explored in more depth also in relation to staff knowledge and length of time in post in the final report with the pre and post intervention data.

Staff Knowledge

We used a hybrid version of the Stella knowledge training activity. It was adapted to ensure that it included a representative sample of questions about each topic (VAW, SU & MH). All questions are worded as statements with a range of options for responses (some true/false others Likert-style, please contact authors for the exact questions and response options). Please see Appendix 3 for Figures 3.1-3.3 which show the levels of knowledge across the three types of organisation in each area. Without running inferential statistics or considering the influence of other factors such as length of time in post and amount of training, which will be investigated in the final report the descriptive statistics suggest that in all areas the highest levels of knowledge tend to be found in staff from VAW organisations in all three areas. Staff from MH and SU organisations frequently had medium levels of knowledge about the three issues. In Nottingham two members of staff from the VAW organisations appeared to have no knowledge about the three topics as they scored zero but further exploration with the post-intervention data is required to explain this.

In order to gain some insight into how staff might try and extend their knowledge about each of the issues we asked them where and how they would search for information. When engaging in a search for information about VAW, practitioners reported drawing on a range of resources, including colleagues, the internet, local directories and resource files:

> *Colleagues. internet local directory* (MH worker, Nottingham)

> *Speak to local NIDAS and national websites, lead within organisation for women specific issues*. (SU worker, Nottingham)

Others emphasized the role of local and personal resource files and directories of appropriate services:

resource file on the ward, my personal resource file as DVA link nurse, internet. (MH worker, Nottingham)

Directory of other services held within the agency (MH worker, Bristol)

Women's Aid (MH worker, Nottingham)

Some took a broader and more formalized approach which included accessing the scientific literature:

Peer group, supervision, literature review, internet review, or directly to specialist services (MH worker, Bristol)

When engaging in a search for information about MH, practitioners also reported drawing on a range of resources, including colleagues, the internet, including dedicated mental health websites, local directories and resource files:

internet, mind and other mental health web sites (SU worker, Hounslow)

ward based resource files, trust intranet, internet. (MH worker, Nottingham)

Directory of other services held within the agency (MH worker, Bristol)

Others suggested conferring within the agency before contacting other specialist agencies:

Internet. Ring contacts or agencies specialising in this area. (SU worker, Bristol)

Confer within agency and contact local specialist agencies (SU worker, Bristol)

Mind website, contact a staff member of the local CMHT (VAW worker, Nottingham)

Finally, when engaging in a search for information about SU, practitioners also reported drawing on a range of resources, including colleagues, the internet and local directories:

Speak to my colleagues to see if they are aware of any agenices, and also check in the directory (VAW worker, Hounslow)

Council websites, online, social services. (VAW worker, Hounslow)

Local Council Website - or IDVA (VAW worker, Hounslow)

Directory of other services at the agency. (MH, Bristol)

Contact a staff member of local EACH & DIAS agency, internet (VAW worker, Bristol)

Others reported a more formal, scholarly approach:

Journals, databases, published guidelines and reviews (MH worker, Hounslow)

Having assessed participants' level of knowledge about the topics and their methods for finding more information we also asked about the knowledge of services and networks that specialise in each area. Because VAW incorporates sexual and domestic violence, there were up to 14 different services or networks staff could have known about but for SM and MH it was only six (for a full list of the options please contact the authors and for tables giving all of the figures for number of services and networks known about please see Appendix 4). There was a very broad distribution of knowledge about other services and networks for all three issues in all three areas. There were very few practitioners who reported not knowing about any services, for those who did it may be that they were new to the role or area of the country so it might be

that when we consider the influence of length of time in post in the final report some explanations are apparent. Generally very few practitioners knew about all the available services/networks for each issue so it is clear that the SPMHI could focus on ways to improve this knowledge. It should be noted however that knowing about a service or network does not imply that practitioners knew how to refer to it or any more detail that it existed. This requires more investigation.

Referral Pathways

Eight agencies did not have any information to provide in the first round of referral pathways data collection, Bristol:

- The Green House
- Addiction Recovery Agency;

Hounslow,

- Victim Support,
- the Community Adult Mental Health Team
- the Community Adult Mental Health Service;

Nottingham,

- Rowan 2,
- Redwood 2
- Gedling Community Adult Mental Health Team

The remaining ten agencies provided data on referral pathways for 171 women (81 from organisations in Nottingham, 75 from organisations in Bristol and 15 from organisations in Hounslow). No MH agencies in Hounslow or Nottingham submitted data. There is a considerable amount of missing data and very low numbers for many of the areas of interest. A brief summary of the general trends is presented here, with a descriptive account of the data highlighting some emerging areas of interest which should be the focus of the SPMHIC's work for the remainder of the project. A detailed breakdown of the figures can be found in Appendix 5 (Tables 5.1-5.5), and further analysis (including the running of inferential statistics) will be undertaken for the final report.

Across all agencies in all areas most of the disclosures of another issue for which a woman might need to be referred are being made either 'on referral', during 'initial assessment' or at a 'follow up appointment'. In terms of the issues that women were presenting with that required referrals across all areas most clients of VAW agencies are being referred on for MH issues whereas from SU agencies referrals are more likely to be for issues around domestic or sexual violence. MH agencies only provided information in Bristol so it is not possible to comment on them at this stage. A wide range of actions were taken by staff who dealt with women with other issues, from signposting to making referrals on behalf of the client. The figures suggest that staff were using the full range of options available to them but with the limited data available it is not possible to see any distinct patterns emerging at the pre-intervention stage. In the first wave of referral pathways data collection practitioners appear to be referring clients to a wide range of agencies for the issues they presented with. It is notable that although some of the organisations involved in the project are listed there are many others that it might be worth the Stella Mental Health Initiative considering in the work it engages in during the rest of the evaluation. In relation to clients with experiences of violence some practitioners emphasized the importance of women's wishes, and the role of risk assessment in making appropriate referrals:

> *Depends on disclosure, client's wishes, refer when appropriate following risk assessment. Women's Refuges, if risk assessment indicative. Liaise with other services.* (SU worker, Nottingham)

Others also focused on the woman's wishes but were also aware of their needs:

> *depends on their needs and what they would like to do. eg if a woman is wanting to flee an abusive partner or family member I would call the national domestic violence helpline or check online what vacancies are available. or approach the local authority and explore other avenues that are needed. also possibly making contacting the police etc if the client wants to.* (VAW worker, Hounslow)

In relation to clients experiencing substance use issues some practitioners emphasized the role of local drug and alcohol services, self help groups and 'walk-in' 'self referral' services:

> *Local drug and alcohol services.* (VAW worker, Hounslow)
>
> *dual diagnosis, local self help groups* (MH worker, Nottingham)
>
> encourage self referral to alcohol/ drugs service walk in service (MH worker, Nottingham)

There were a similar wide range of potential referral pathways for clients experiencing substance use issues including local mental health services, statutory and non statutory; GPs and community mental health teams; crisis teams and safeguarding teams. Very few staff reported the reasons clients gave for not engaging after the first contact, it is unclear whether this is because staff did ask clients the reasons but none were forthcoming, whether staff did not or were not able to ask the clients for their reasons or because they chose not to report the reasons to the evaluation team. As noted in the REA, this may be a particularly difficult client group to engage and monitor, for a number of reasons, including the level of mistrust and anxiety these women may have when engaging with services and their experience or expectation of stigma and discrimination from service providers.

Group Ecograms by Area

Each focus group worked together to produce a group ecogram depicting how their organisations could work together to improve responses to women who are experiencing violence, substance use and mental health issues. For these ecograms, the centre circle represents a woman experiencing these intersecting issues.

Hounslow

The Hounslow focus group placed a 'survivor' at the centre of their group ecogram (Figure 1, below). Potential referral pathways were highlighted by the group in pink, with heavier lines

indicating strong connections, and dashed lines indicating connections in need of strengthening. Possible barriers and facilitators were indicated in black text.

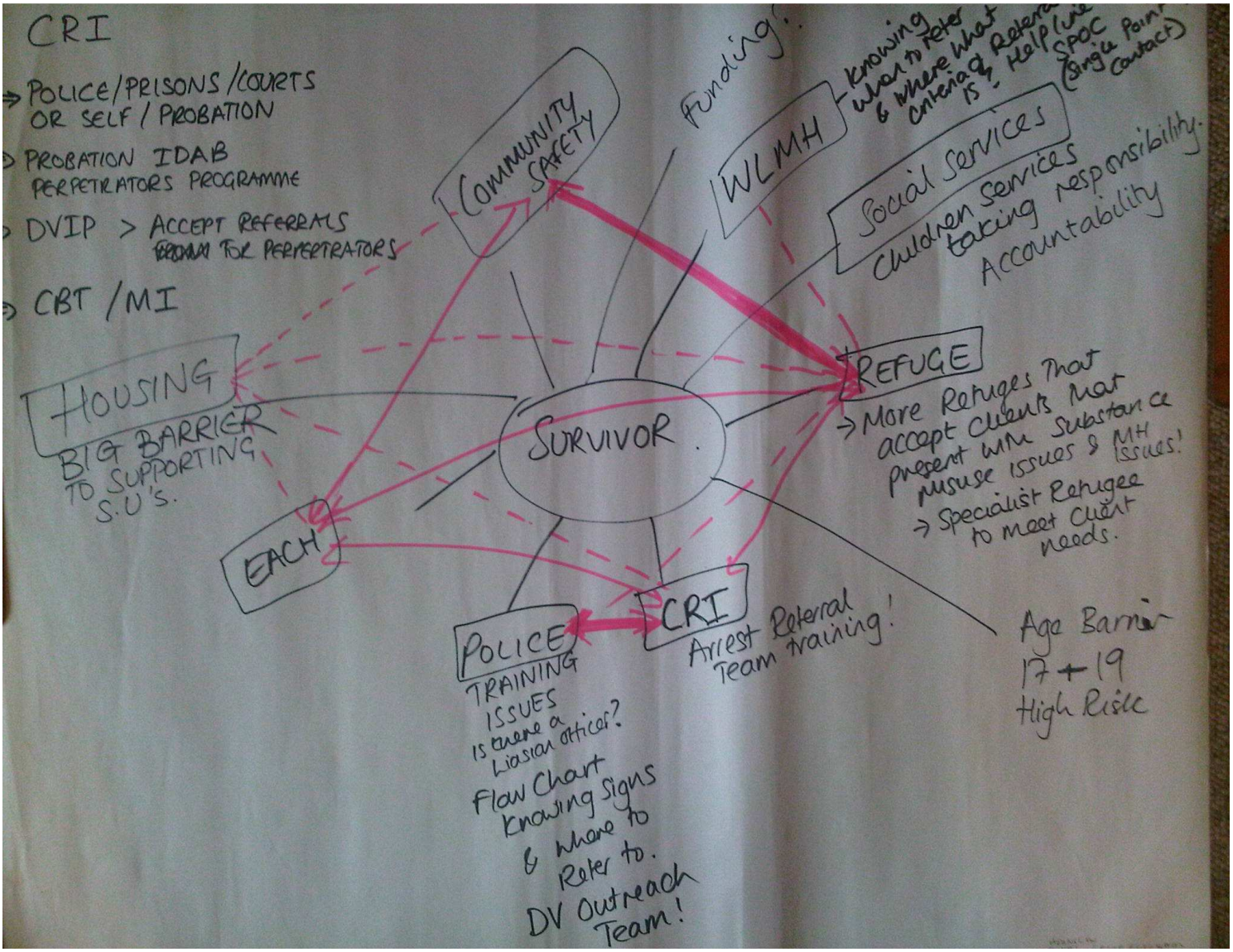


Figure 1. Group Ecogram Hounslow

The Hounslow group emphasized strong referral pathways (represented by heavy pink lines) between police and CRI, and between Refuge and Community Safety. Moderately strong referral pathways (represented by plain pink lines) were depicted between CRI and EACH; Community Safety and EACH; and Refuge and CRI. Connections in need of strengthening

(represented by dashed pink lines) included those between housing services and community safety; housing services and EACH; housing services and CRI; housing services and Refuge; between Refuge and Police; and between Refuge and WLMH.

Possible barriers (indicated in black text) for Police included training issues; queries about the existence of a liaison officer; the need for a flow chart depicting 'signs' and where to refer to; the need for a DV Outreach Team. Potential barriers (indicated in black text) for WLMH include a lack of knowledge about when and where to refer women; what criteria should be applied in making referrals; the need for a helpline and single point of contact. Identified barriers (indicated in black text) for Refuge include the need for more refuges to accept clients that present with substance use issues and mental health issues; and the need for a specialist refuge to meet clients' needs. Housing was also identified as a significant barrier to supporting women who were substance users. Young women (17-19) were identified as being at particularly high risk. It is interesting to note that practitioners in Hounslow only identified barriers not facilitators and that risk assessment processes were not mentioned at all.

Bristol

The Bristol focus group placed a 'client' at the centre of their group ecogram (Figure 2, below). Potential referral pathways were highlighted by the group with black arrows. A question mark was used to indicate a key connection in need of strengthening. Possible barriers and facilitators were not overtly represented by the group's ecogram.

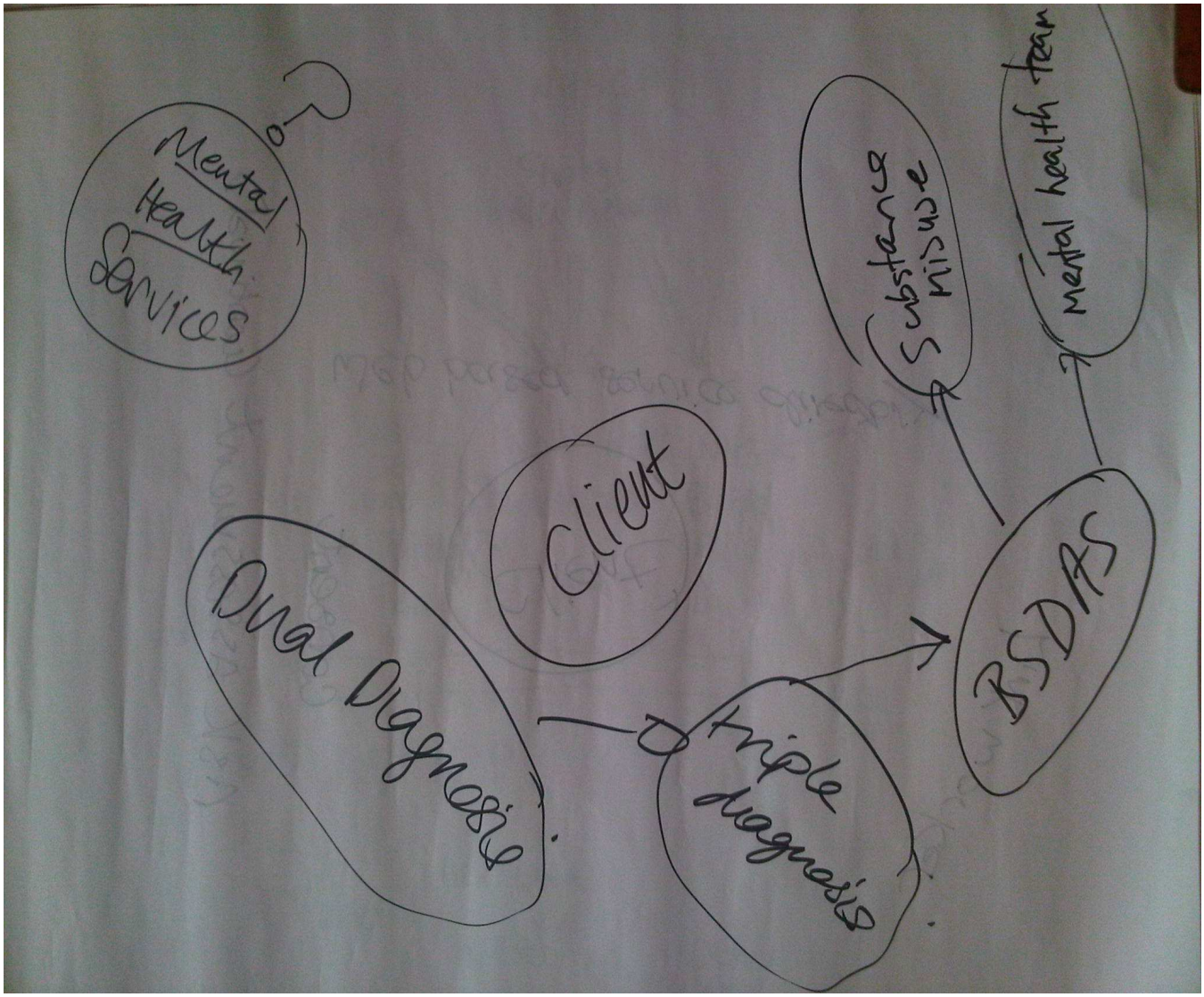


Figure 2. Group Ecogram Bristol

The Bristol group's ecogram was more parsimonious than the ecograms produced by the focus groups from the other two areas. This was due to an initial misinterpretation of the instructions, and a consequent lack of time to complete a detailed group ecogram. Nevertheless, this ecogram is striking in that it clearly presents, via the use of a question mark, the location of a significant barrier to integrative work for women with overlapping needs. Mental health services are dislocated from both the 'client' and from the other services represented. Incorporating mental MH services would appear to be a significant challenge for

the Bristol group. The Bristol group were also concerned by the complexity of the issues represented by clients with 'dual diagnosis' and 'triple diagnosis', and they highlighted the role of the connection between BSDAS and substance use, and the mental health team.

Nottingham

The Nottingham focus group placed a 'client/survivor' at the centre of their group ecogram (Figure 3, on the next page). Potential referral pathways were highlighted by the group with black lines.

The Nottingham group produced the most detailed ecogram of each of the three areas. At the centre of the ecogram is the client/survivor, who is closely surrounded by circles marked 'family', 'children', 'perpetrator', and 'community'. They also indicated a potential role for preventative work. This ecogram is divided into quadrants (represented by pale blue lines). Each quadrant represents one of the intersecting issues: sexual violence; drugs and alcohol; mental health; and domestic violence services. In each quadrant, the group placed relevant services and mapped the referral pathways the client might take to these. Over 35 services were represented.

The group also noted separately (in green text) the measures that they thought would lead to 'better outcomes'. These included improved self-referral pathways; standardized assessment leading to standardized responses and referral pathways; more information on available services; routes for non-medical referrals; process for case challenge; appropriate/safe discharge planning; and the importance of dispelling myths. They also offered a strategic statement: "think family, resilience, recovery."

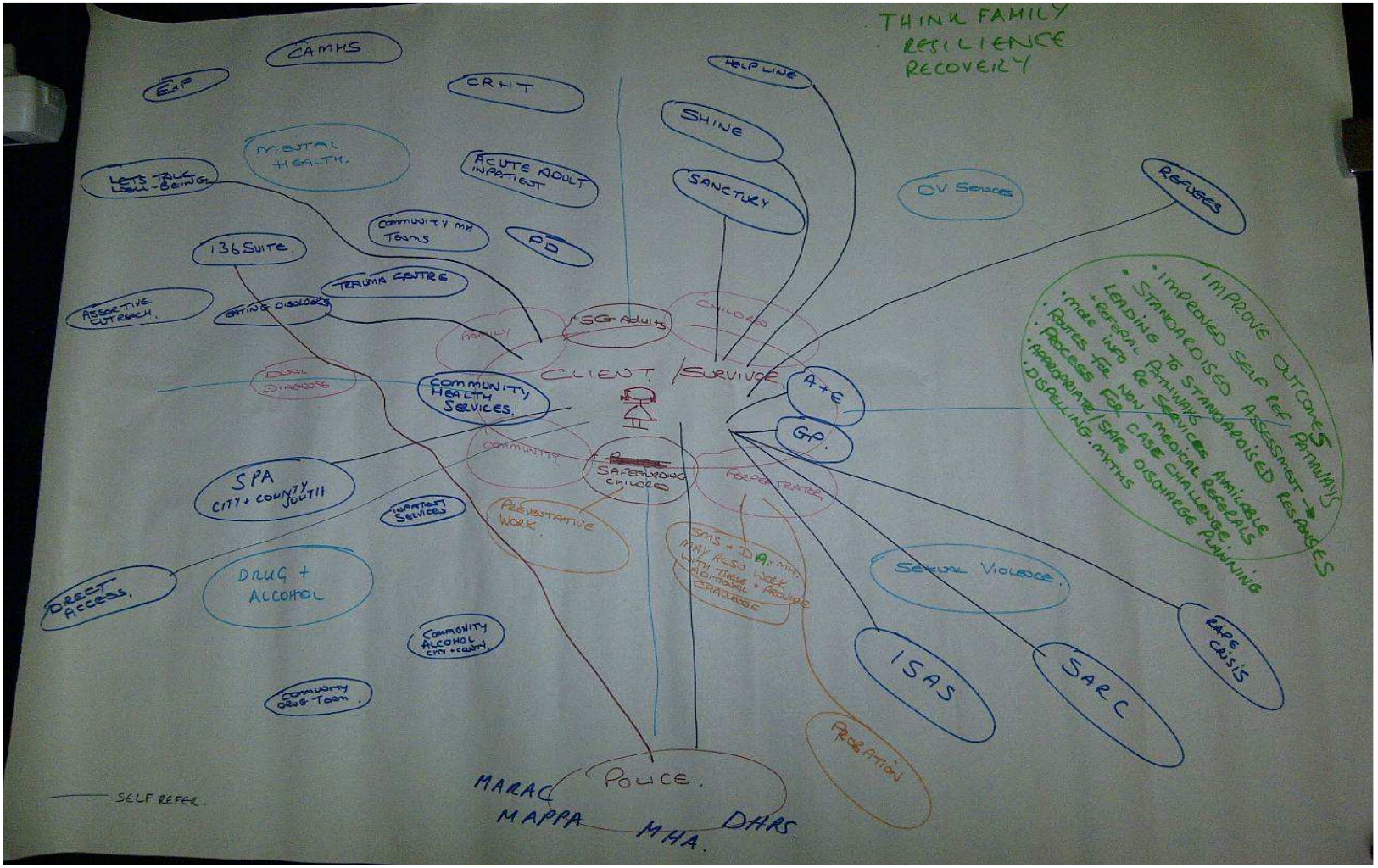


Figure 3. Group Ecogram Nottingham

Monitoring Data

As was the case for the staff confidence and referral pathways data at this pre-intervention stage, time and data constraints did not permit the running of inferential statistics, therefore we cannot say for certain where differences exist. However in the paragraphs that follow we provide a descriptive account of the data highlighting some emerging areas of interest which will be explored in the final report with the post-intervention data and should be the focus of the SPMIHC's work for the remainder of the intervention.

Staff from all organisations from all of the areas in the evaluation had vastly different numbers of women on their caseloads. Table 3 suggests that across all three areas some staff from VAW organisations had the highest number of women on their caseloads. It should be noted that this does not mean necessarily that VAW practitioners are working harder than those from SU or MH agencies. It may be the case that staff from VAW agencies tend to have high caseloads but spend short amounts of time with clients whereas SU and MH staff have fewer clients but spend more time with them. This simple count of workload may not be the best indicator of who is the most under-resourced and overstretched but this requires more investigation. It should also be noted that for all organisations in all areas bar one the mean number of women on staff's caseloads was less than ten.

Table 3. The range of women staff from different agencies and areas had on their caseloads

		Range of number of women on caseload		
		Smallest Caseload	*Largest Caseload*	*Mean*
Bristol	VAW	0	48	22
	MH	0	11	4.75
	SU	0	20	4.54
Hounslow	VAW	0	50	9.94
	MH	0	30	5.91
	SU	0	13	6
Nottingham	VAW	0	30	9.18
	MH	0	18	7.55
	SU	0	14	6.75

Table 4 shows the number of women staff had discussed each of the issues with as part of their routine work in the three months prior to completing the questionnaire and the mean number of women staff had on their case load. It is necessary to consider these data together because whilst it appears for example, that staff from MH agencies ask the least number of women about violence, on average they have fewer clients than staff from VAW agencies so less people to ask. The following general trends are also noted.

- Approximately a third of staff from each agency in each area did not answer or did not discuss violence issues with any women in the last three months.
- The majority of staff from all organisations (between 66-95%) had discussed SU issues with between none and five women in the last 3 months.
- Routine enquiries about MH issues appear to be less frequent in MH agencies in all three areas than in SU and VAW agencies. This cannot be wholly accounted for by the low numbers of women on the caseloads of staff from MH agencies as the mean caseloads are almost identical to those from SU agencies.

Table 4. Numbers of women staff had discussed the three issues with as part of their routine work in the last three months

Area	Agency Specialism	Mean n of women on caseload	Issue	Number of women issue discussed with				
				0 n (%)	1-5 n (%)	6-10 n (%)	11-20 n (%)	21 or more n (%)
Bristol	VAW	22	VAW	2 (33.3)	0 (0)	0 (0)	1(16.7)	3 (50)
			MH	0 (0)	2 (33.3)	1 (16.7)	3 (50)	0 (0)
			SU	0 (0)	2 (33.3)	2 (33.3)	2 (33.3)	0 (0)
	MH	4.75	VAW	1 (25)	3 (75)	0 (0)	0 (0)	0 (0)
			MH	1 (25)	2 (50)	0 (0)	1 (25)	0 (0)
			SU	2 (50)	2 (50)	0 (0)	0 (0)	0 (0)
	SU	4.54	VAW	9 (34.6)	11 (42.3)	2 (7.7)	3 (11.5)	1 (3.8)
			MH	5 (19.2)	13 (50)	5 (19.2)	2 (7.7)	1 (3.8)
			SU	7 (26.9)	11 (42.3)	2 (7.7)	3 (11.5)	3 (11.5)
Hounslow	VAW	9.94	VAW	1 (5.9)	1 (5.9)	6 (35.3)	3 (17.6)	6 (35.3)
			MH	4 (23.5)	5 (29.4)	4 (23.5)	1 (5.9)	3 (17.6)
			SU	6 (35.3)	8 (47.1)	2 (11.8)	1 (5.9)	0 (0)
	MH	5.91	VAW	5 (45.5)	4 (36.4)	1 (9.1)	0 (0)	1 (9.1)
			MH	4 (36.4)	3 (27.3)	0 (0)	1 (9.1)	3 (27.3)
			SU	6 (54.6)	3 (27.3)	0 (0)	0 (0)	2 (18.2)
	SU	6	VAW	1 (33.3)	0 (0)	0 (0)	2 (66.7)	0 (0)
			MH	1 (33.3)	0 (0)	1 (33.3)	1 (33.3)	0 (0)
			SU	1 (33.3)	1 (33.3)	0 (0)	1 (33.3)	0 (0)
Nottingham	VAW	9.18	VAW	6 (35.3)	2 (11.8)	2 (11.8)	2 (11.8)	5 (29.4)
			MH	6 (35.5)	3 (17.6)	3 (17.6)	2 (11.8)	3 (17.6)
			SU	8 (47.1)	4 (23.5)	2 (11.8)	1 (5.9)	2 (11.8)
	MH	7.55	VAW	7 (35)	9 (45)	0 (0)	2 (10)	2(10)
			MH	5 (25)	2 (10)	3 (15)	3 (15)	7 (35)
			SU	5 (25)	8 (40)	3 (15)	2 (10)	2 (10)
	SU	6.75	VAW	1 (12.5)	4 (50)	0 (0)	1 (12.5)	2 (25)
			MH	1 (12.5)	1 (12.5)	1 (12.5)	3 (37.5)	2 (25)
			SU	1 (12.5)	1 (12.5)	1 (12.5)	2 (25)	3 (37.5)

Note: 0 refers to both when staff answered none or didn't answer.

We next asked staff how they record information about VAW, SU and MH (see Appendix 6, Tables 6.1-6.3). Unfortunately large numbers did not answer these questions, so it is not possible to draw out much at this stage. Most staff in each area reported that they either had a specific section of their records to include information about each of the three issues or that they included it as an 'additional information' note on their clients records. A significant

proportion of staff from Bristol made other comments about where they recorded the information. These included, “not my role [to record this information]”; “Possible general notation in case notes”; and “I record all my notes in one place.” Some staff from Hounslow also provided other comments about where they recorded information which include: “as part of the progress notes we keep with the other information”; and “all goes into progress notes and gets added onto the risk assessment Trust mental Heath notes”; “For violence in safety”, and “I discuss the development of the medication and how she is feeling every time I key work them.”

As well as asking practitioners how they recorded information about the three issues, we also enquired if there were any barriers to recording such information. Many practitioners reported that there were ‘no barriers’, or simply left this response field blank. Of those that did report barriers, these were concerned with “data protection and confidentiality”, with the fear that the information might have to be “called in court” and potentially used against the women:

> *That these issues, if I record them in the contact notes, can be disclosed to the CPS and therefore to the defence barrister in a crown court case and be used to undermine the client's credibility or reliability as a witness. That shouldn't happen but sometimes does.* (SV Worker, Nottingham)

and a range of more mundane pragmatic concerns with the limitations of the available forms. For example, one practitioner noted that it was “difficult to separate out as notes are integrated” and another reported there was no opportunity to provide detailed information on these intersecting issues. Others were concerned that they did not possess the “right terminology” to effectively record intersecting issues.

Related to how staff record information about their clients we also asked about how staff shared information about clients within and between organisations (See Appendix 7, Tables 7.1-7.3). These data provide limited insight into information sharing processes because a large

number of staff from Nottingham and Hounslow did not answer the questions. The general patters of sharing are:

- Whilst the majority of staff from agencies in Nottingham reported that they would share information about clients within their organisation and with other organisations some staff from mental health agencies reported that they would never share information about clients within their organisation and a few from MH and VAW agencies reported that they would never share information about clients with other organisations.
- In Bristol apart from a handful of staff from SU agencies who reported that they would never share information about a client's MH issues within their organisation, staff from all organisations would share information about clients within their organisations. A small proportion of staff from each types of organisation reported that they would not share information with other organisations about the three issues but the majority said that they would.
- In Hounslow, all staff who answered the questions about sharing information about clients within and between organisations reported that they would share information about any of the issues within their organisation and with other organisations.

Considerable differences can therefore be seen between the three areas in terms of their practices around sharing information both within and between their organisations. More insight is provided into practitioners' concerns about sharing information within and between services when their free text responses are considered. Some reported 'no barriers' to sharing data about women's experiences of violence, substance use and mental health issues:

> *No barriers. Multi-agency working - Stat.and non-stat. organisations and sharing of information within Notts. Healthcare Policies and procedures guidance.* (SU Worker, Nottingham)

Others added that as they had an information sharing protocol, there were no barriers to information sharing.

> *No barriers - signed up to an Information Sharing Protocol* (VAW Worker, Nottingham)

Others emphasized the complex relationship between confidentiality, consent, and safeguarding issues:

> *Depending on the situation and the consent of the client we would share information with other relevant services - if there were safeguarding issues then consent would not get in the way of sharing information* (SU worker, Bristol)

> *According to our confidentiality policy and Child Protection Policies* (SU worker, Bristol)

Most practitioners indicated that safeguarding issues should take precedence, and that child protection issues override most information sharing protocols even if it means a breach of what would otherwise be considered 'confidential':

> *Unless there is a present dangerous risk to the woman, I make sure she is ready and able to make contact and/or engage in specialist support as action without preparation might aggravate or instigate a higher risk to client. (*SU worker, Bristol)

However, some practitioners had significant concerns around data protection and client confidentiality. Many indicated that they felt that a lack of client consent was a major barrier:

> *Sharing consent can be difficult if client is unwilling to allow information to be shared within networking services*. (SU worker, Bristol)

Others reported that many professionals were wary of information sharing, despite the clear benefits of this practice:

> *speaking to professionals in different agencies as there is a generalised fear of information sharing, everybody sees the benefits but are fearful because of confidentiality protocols* (SU Worker, Nottingham)

The consent of clients, prior to sharing information, was emphasized by some practitioners, as was the importance of observing confidentiality policy, and being attuned to the level of risk faced by clients and others:

> *Phone contact with workers involved- Social Workers, Probation, Mental Health Team, consent from client prior to sharing. Attendance at meetings, MAPPA, MARAC, Children's Services, GP, other Professionals involved with client. Referral to specific agencies if appropriate* (SU worker, Nottingham)

> *By phone, letter or email. Other services working with the client ,observing confidentiality policy and using consent form. The only time I would share information with relevant services, without clients permission, is if I felt that the client or someone else was at risk*. (SU worker, Bristol)

Some practitioners reported that mental health services may pose a specific barrier to information sharing by 'refusing' to share information:

> *Most common barrier is with statutory/mental health services who can refuse to share information - sometimes this is inappropriate.* (SU worker, Bristol)

Practitioners indicated that the lack of 'local information sharing agreements' was a significant barrier to information sharing.

lack of appropriate local information sharing agreements - causing confusion and conflict between a desire to share and the risks of doing so (SU worker, Nottingham)

In relation to sharing information about VAW within their services most practitioners reported that that would share such information 'during supervision' or 'with my manager'. Others asserted that they would share such information during 'casework meetings' or with referral agencies, if appropriate.

Share information with my colleagues during Casework meetings (VAW worker, Hounslow)

I am a women's worker and I share my caseload within my team during supervision and team supervision and others if necessary ie; MARAC referral to other services or gaining information from previous service or referrer. (SU worker, Nottingham)

First with manager then a referral agency if the client needs to access other service. (VAW worker, Hounslow)

Practitioners reported sharing information about violence experienced by their clients with external agencies, given the consent of the service user, with agencies who have co-signed information sharing protocols, and as part of multidisciplinary team meetings. If a client were at heightened risk, practitioners would share information without their consent:

I share info verbally or in written format with external agencies, such as the Police, healthcare workers, housing providers and legal workers. I have written consent to do so from the service user. (VAW worker, Hounslow)

Some practitioners reported seeking information from specialist services, without disclosing client specific details:

Also may ring a violence against women service to get advice on a 'hypothetical' question to see what they would recommend. (SU worker, Bristol)

Others reported that information sharing regularly occurred as part of their multidisciplinary team meetings:

Share with outreach team if woman is signposted to them within the multi discipliary team through notes, handovers, weekly reviews. (VAW worker, Nottingham)

Information sharing protocols were described as facilitating this process:

With agencies who have signed up to info sharing protocols for eg MARAC. (VAW worker, Hounslow)

Most practitioners reported that they would share information with other relevant agencies. The concerns that practitioners gave for not sharing information with external services included confidentiality concerns and aggravating risks to the client:

If agency not signed up to the Information Sharing Protocol or if it not relevant to share info (VAW worker, Nottingham)

As with sharing information internally about women experiencing violence, most practitioners reported that that would share information about women's substance use 'during supervision' or 'with my manager'. Others asserted that they would share such information during 'casework meetings' or with referral agencies, if appropriate.

With colleagues during our weekly client review meetings and additionally whenever necessary (SU worker, Bristol)

her support worker if she is accessing support from another service in the organization (VAW worker, Nottingham)

Practitioners reported sharing information about the substance use of their clients with external agencies, given the consent of the service user, with agencies who have co-signed information sharing protocols, and with agencies 'working in partnership'. In the event of safeguarding issues, practitioners would share information without their consent, but many qualified this by stressing that such agencies should be part of the protocol for information sharing in order for this to occur:

With agencies who have signed up to info sharing protocols for eg MARAC. (VAW, Hounslow)

Others emphasized the importance of a women 'wanting support' with substance use issues, and of her 'permission' to seek support from another service.

On a need to know basis with the women's permission (VAW worker, Hounslow)

if the woman wants support from another service so only with her permission (VAW worker, Bristol)

With services working in partnership to support the women with her consent. (SU worker, Hounslow)

Some practitioners stressed that they would assess the 'seriousness of the situation' with their manager prior to sharing any information:

> *the information about the client would be shared with the agency that would be relevent for the client and if of benefit to her. this is not done without possibly discussing with a manager first depending on situation and how serious it is etc.* (VAW worker, Hounslow)

As with sharing information internally about women experiencing violence, and substance use issues, most practitioners reported that that would share information about women's mental health issues 'during supervision' or 'with my manager'. Others asserted that they would share such information during 'casework meetings' or with referral agencies, if appropriate.

Some practitioners asserted that they would only share such information internally if it were a 'serious situation' and they 'needed guidance':

> *Only in serious situations, if we are concerned for the client and need guidance.* (VAW worker, Hounslow)

> *Share information with Managers and colleagues when needed* (VAW worker, Hounslow)

Others described this as a daily occurrence:

> documented daily in notes, through handovers and in reviews with all members of the multi disciplinary team. (MH worker, Nottingham)

Practitioners reported sharing information about the mental health issues of their clients with external agencies, given the consent of the service user, with agencies who have co-signed information sharing protocols, and with agencies 'working in partnership'. In the event of safeguarding issues, practitioners would share information without their consent. Further, practitioners reported taking into account the 'level of mental health' before disclosing such information:

I would take the level of mental health into question before disclosing. (mild off days/suicidal risk) (SU worker, Bristol)

Others stressed the importance of clients' consent, and agreement to the choice of agency information is shared with:

With her consent and with an agreed agency (MH worker, Hounslow)

with clients permission and consent (MH worker, Hounslow)

As with information sharing with regard to the other intersecting issues, practitioners reported waiving client consent when the client's mental health posed a 'significant risk to herself/others':

I work with a lot of agencies with most clients. I would gain consent from the client to share information with agencies. I would break confidentiality if a women's mental health issues poses significant risk to herself/ others (SU worker, Bristol)

With the client's consent and/or if a child/young person is at risk. I may contact GP, Emergency Mental Health Crisis Team, Social Services. (SV worker, Bristol)

The key role of information sharing protocols in sharing mental health information was also emphasized by practitioners:

With agencies who have signed upto info sharing protocols for eg MARAC. (VAW worker, Hounslow)

Agencies signed up to Information Sharing Protocol agreement (VAW worker, Nottingham)

Adoption of AVA/Stella Project priorities within the target services/areas

Only a very brief overview of the policies and procedures obtained at the pre-intervention stage is provided in this report. It is not possible to provide a full picture of all policy documents as they could not all be located or accessed (please contact the authors if you would like copies of the documents we did access).

Bristol

Of the ten policies analysed from the Bristol area, five referred to Violence against Women, five to Mental Health and six to Substance use issues. Two policies referred to two of the above mentioned issues, and two other policies referred to all three of the issues. All organisations were working in partnership with others in varying capabilities. NHS organisations worked with a range of statutory organisations and also with non-statutory organisations, the latter particularly with non-health organisations (e.g. Crime and Drugs Partnership). Non-governmental organisations were working with a variety of other agencies and services, and some government organisations such as the Police and GPs. Somewhat surprisingly the NHS Bristol strategic plan did not refer to violence against women and girls at all, but that the alcohol strategy included actions around domestic violence training for alcohol services and to employ a domestic violence worker. At the post-intervention stage of the evaluation we will monitor closely whether there are changes to the NHS Bristol strategic plan and if the actions around domestic violence in the alcohol strategy have been implemented.

Hounslow

Of eleven policies analysed, seven referred to VAW, nine to MH and seven to SU issues. Four policies highlighted two of the issues, and four of the high-level documents discussed all three issues. As in Bristol, all organisations worked in partnership with other organisations to varying degrees, and followed a similar pattern to Bristol in terms of type of organisation.

Nottingham

For Nottingham, eighteen polices were analysed. Fourteen referred to VAW, nine to MH and 12 to SU. Of these, nine mentioned two issues, and four high-level documents discussed all three issues. Similar to Bristol and Hounslow, Nottingham organisations also worked in partnership with a variety of other organisations and agencies.

From an analysis of the policies and procedures of organisations working in Bristol, Hounslow and Nottingham, it appears that these organisations are working in partnership with a variety of other local statutory and non-governmental organisations, agencies and services. Some policies explained the nature of their relationship with other organisations, whilst others listed the organisations they worked with. Analysis of the documents does not provide any insight into the policy-level commitment to act on these issues in a joined-up fashion. At the post-intervention stage we hope to be able to map whether the same documents, and any new ones, have more cross-referencing in terms of the three issues and inter-agency working.

Interim Recommendations

We recommend that:

- Practitioners from each of the areas should be encouraged to continue to work together to build a shared understanding of their different professional and practice philosophies, to foster mutual trust and respect, and to build a consensus on how best to integrate services for women with these overlapping issues.

- Agencies should continue to invest in improving the training, confidence and knowledge of their staff of these intersecting issues.

- Practitioners should be encouraged to share information responsibly, where appropriate, and to become more confident in recognizing when it is responsible and appropriate to do so, and in navigating situations where they may experience conflicting responsibilities.

- To enhance the sustainability of the Stella Mental Health Initiative project beyond the immediate funding period it is recommended that more organisations, services and agencies are engaged in the project's networks. Related to this mechanisms should be set up to ensure that the input from AVA is cascaded to new members of staff and those who have not received it. The SPMHIC should look at ways of developing best practice models of these mechanisms.

- The importance of collecting data on referral pathways needs to be given prominence in the SPMHIC work. We suggest that she does some more work with agencies to assist them in setting up simple mechanisms for doing so.

- The process for referring women within and between agencies often appears to rely on 'old relationships'. We suggest that agencies focus on developing formalised clear referral pathways that exist independent of the individuals involved in them.

- To more accurately capture practitioners' understandings of violence against women, and their experiences of relevant training, it is recommended that the wording of the survey, and any future data collection instruments, or communications, be adapted to reflect the terminology practitioners are familiar with.

- Barriers to effective joint working should be clearly identified, such as where agencies have rules or processes that mean clients with certain issues cannot be referred on to them. We suggest that when these are identified mechanisms should be developed to address these rules and processes and to also identify and challenge the negative preconceptions about women with overlapping and complex needs that may undergird these rules.

- It is notable that although some of the organisations involved in the project were referred to as places practitioners referred women to there were also many others that it might be worth the SPMHIC considering engaging with during the rest of project.

- The wide variation in caseloads among the different agencies involved in the project requires further investigation, alongside this it is recommended that any training materials that are developed should recognise and value the different approaches to working with clients.

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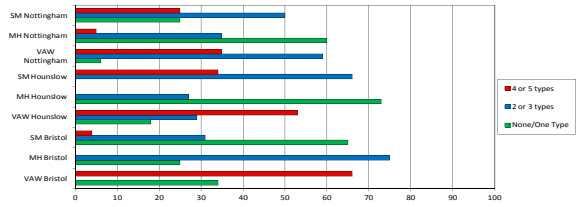
Contents of Appendices

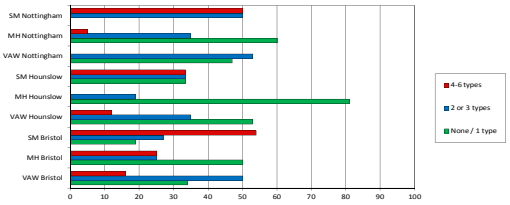
Appendix 7 Sharing information within and between organisations in the three areas

Appendix 1 – Amount of types of training received on VAW, MH and SU



% of participants

Figure 1.1. Percentages of participants from each organisation and amount of types of training on VAW received



% of participants

Figure 1.2. Percentages of participants from each organisation and the amount of types of training on SU they had received

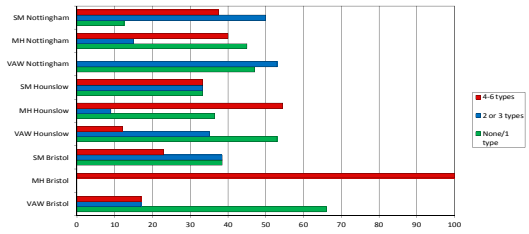


Figure 1.3. Percentages of participants from each organisation and the amount of types of training on MH they had received

Appendix 2 – Perceptions of training and confidence

Table 2.1. Perception of training and confidence in Bristol

VAW Issues		Perception of Amount of Training				Confidence Talking About			
		Didn't answer n (%)	*Too Little n (%)*	*The Right Amount n (%)*	*Too Much n (%)*	*Didn't answer n (%)*	*Low n (%)*	*Medium n (%)*	*High n (%)*
Organisation	VAW	0 (0)	0 (0)	6 (100)	0 (0)	0 (0)	(0)	0 (0)	6 (100)
	MH	0 (0)	2 (50)	2 (50)	0 (0)	0 (0)	(0)	2 (50)	2 (50)
	SU	1 (3.8)	14 (53.8)	11 (42.3)	0 (0)	0 (0)	5 (19.2)	9 (34.6)	12 (46.1)
MH Issues									
Organisation	VAW	0 (0)	4 (66.7)	2 (33.3)	0 (0)	0 (0)	3 (50)	0 (0)	3 (50)
	MH	0 (0)	1 (25)	3 (75)	0 (0)	0 (0)	2 (50)	1 (25)	1 (25)
	SU	0 (0)	15 (57.7)	10 (38.5)	1 (3.8)	0 (0)	2 (7.6)	1 (3.8)	23 (88.5)
SU Issues									
Organisation	VAW	0 (0)	4 (66.7)	2 (33.3)	0 (0)	0 (0)	3 (50)	1 (16.7)	2 (33.3)
	MH	0 (0)	3 (75)	1 (25)	0 (0)	1 (25)	0 (0)	0 (0)	3 (75)
	SU	3 (11.5)	2 (7.7)	21 (80.8)	0 (0)	1 (3.8)	2 (7.6)	9 (34.6)	14 (53.9)

Table 2.2. Perception of training and confidence in Hounslow

		Perception of Amount of Training				Confidence Talking About			
VAW Issues		*Didn't answer n (%)*	*Too Little n (%)*	*The Right Amount n (%)*	*Too Much n (%)*	*Didn't answer n (%)*	*Low n (%)*	*Medium n (%)*	*High n (%)*
Organisation	VAW	0 (0)	1 (5.9)	16 (94.1)	0 (0)	0 (0)	0 (0)	0 (0)	17 (100)
	MH	0 (0)	8 (72.7)	3 (27.3)	0 (0)	0 (0)	5 (45.5)	3 (27.3)	3 (27.3)
	SU	0 (0)	0 (0)	3 (100)	0 (0)	0 (0)	0 (0)	0 (0)	3 (100)
MH Issues									
Organisation	VAW	0 (0)	14 (66.7)	3 (33.3)	0 (0)	1 (5.9)	5 (29.4)	4 (23.5)	7 (41.1)
	MH	0 (0)	0 (0)	11 (100)	0 (0)	0 (0)	5 (45.5)	4 (36.4)	2 (18.2)
	SU	0 (0)	2 (66.7)	0 (0)	1(33.3)	0 (0)	0 (0)	1 (33.3)	2 (66.7)
SU Issues									
Organisation	VAW	0 (0)	12 (70.6)	4 (23.5)	1 (5.9)	1 (5.9)	4 (23.6)	5 (29.4)	7 (41.2)
	MH	0 (0)	7 (63.3)	4 (36.4)	0 (0)	0 (0)	1 (9.1)	3 (27.3)	7 (63.7)
	SU	0 (0)	1 (33.3)	2 (66.7)	0 (0)	0 (0)	0 (0)	1 (33.3)	2 (66.6)

Table 2.3. Perception of training and confidence in Nottingham

VAW Issues		Perception of Amount of Training				Confidence Talking About			
		Didn't answer n (%)	*Too Little n (%)*	*The Right Amount n (%)*	*Too Much n (%)*	*Didn't answer n (%)*	*Low n (%)*	*Medium n (%)*	*High n (%)*
Organisation	VAW	0 (0)	1 (5.9)	15 (88.2)	1 (5.9)	0 (0)	0 (0)	1 (5.9)	16 (94.1)
	MH	1 (5)	14 (70)	5 (25)	0 (0)	1 (5)	3 (25)	3 (25)	5 (45)
	SU	0 (0)	6 (75)	2 (25)	0 (0)	0 (0)	0 (0)	3 (37.5)	5 (62.5)
MH Issues									
Organisation	VAW	1 (5.9)	4 (23.5)	2 (70.6)	0 (0)	0 (0)	3 (17.6)	7 (41.2)	7 (41.2)
	MH	0 (0)	1 (30)	3 (70)	0 (0)	1 (5)	6 (30)	4 (20)	9 (45)
	SU	0 (0)	3 (37.5)	5 (62.5)	0 (0)	0 (0)	0 (0)	0 (0)	8 (100)
SU Issues									
Organisation	VAW	1 (5.9)	8 (47.1)	8 (47.1)	0 (0)	1 (5.9)	2 (11.8)	6 (35.3)	8 (47)
	MH	2 (10)	12 (60)	6 (30)	0 (0)	5 (25)	1 (5)	3 (15)	11 (55)
	SU	0 (0)	2 (25)	6 (75)	0 (0)	1 (12.5)	0 (0)	2 (25)	5 (62.5)

Appendix 3 – Staff Knowledge Levels

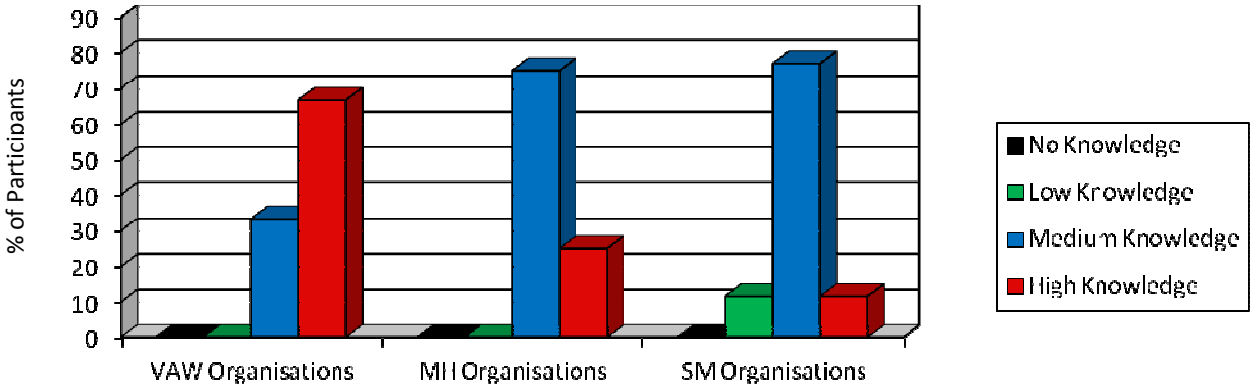


Figure 3.1. Staff from Bristol Organisations knowledge levels

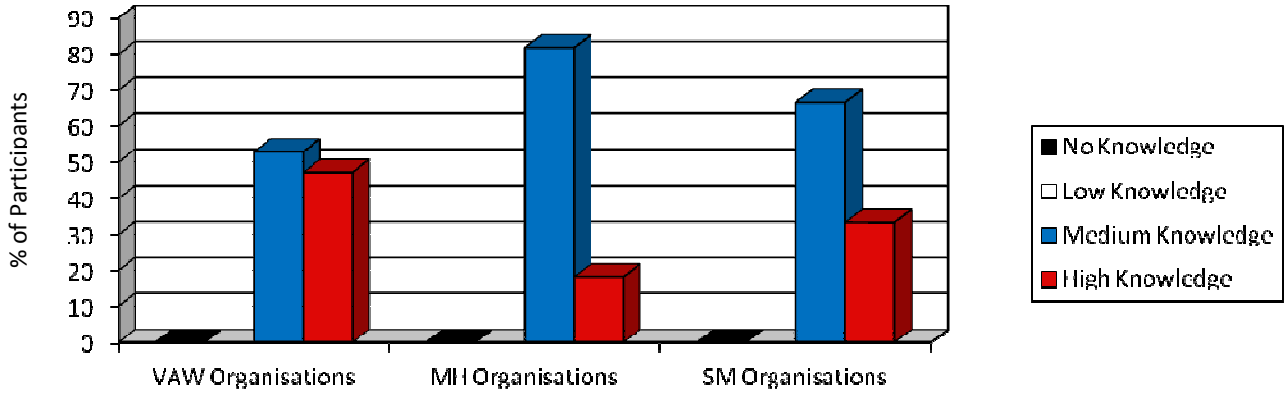


Figure 3.2. Staff from Hounslow Organisations knowledge levels

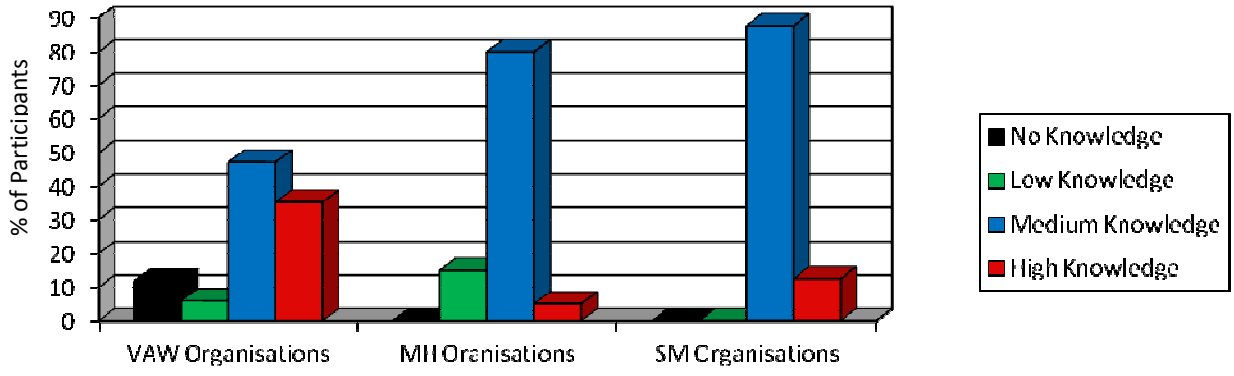


Figure 3.3. Staff from Nottingham Organisations knowledge levels

Appendix 4 - Staff Knowledge about services and networks

Table 4.1. Bristol staff knowledge about services/networks from VAW, MH and SU

		Participants from VAW Organisations n (%)	Participants from MH Organisations n (%)	Participants from SU Organisations n (%)
Number of VAW services / networks known about	None	0 (0)	0 (0)	1 (3.8)
	1 – 4	1 (16.7)	2 (50)	13 (50)
	5 – 8	3 (34.3)	2 (50)	11 (42.3)
	9 – 12	3 (50)	0 (0)	1 (3.8)
Number of SU services / networks known about	None	0 (0)	1 (25)	0 (0)
	1 – 2	2 (33.3)	1 (25)	6 (23.1)
	3 – 4	4 (66.7)	2 (50)	14 (53.8)
	5 - 6	0 (0)	0 (0)	6 (23.1)
Number of MH services / networks known about	None	0 (0)	0 (0)	1 (3.8)
	1 – 2	3 (50)	0 (0)	10 (38.5)
	3 – 4	3 (50)	4 (100)	13 (50)
	5 - 6	0 (0)	0 (0)	2 (7.7)

Table 4.2. Nottingham staff knowledge about services/networks from VAW, MH and SU

		Participants from VAW Organisations n (%)	Participants from MH Organisations n (%)	Participants from SU Organisations n (%)
Number of VAW services / networks known about	None	3 (17.6)	1 (5)	0 (0)
	1 – 4	1 (5.9)	11 (55)	4 (50)
	5 – 8	10 (58.8)	8 (40)	4 (50)
	9 – 12	3 (17.6)	0 (0)	0 (0)
Number of SU services / networks known about	None	3 (17.6)	1 (5)	0 (0)
	1 – 2	7 (41.2)	10 (50)	0 (0)
	3 – 4	7 (41.2)	9 (45)	5 (62.5)
	5 - 6	0 (0)	0 (0)	3 (37.5)
Number of MH services / networks known about	None	3 (17.6)	1 (5)	0 (0)
	1 – 2	8 (47.1)	8 (40)	2 (25)
	3 – 4	6 (35.3)	8 (40)	6 (75)
	5 - 6	0 (0)	3 (15)	0 (0)

Table 4.3. Hounslow staff knowledge about services/networks from VAW, MH and SU

		Participants from VAW Organisations n (%)	Participants from MH Organisations n (%)	Participants from SU Organisations n (%)
Number of VAW services / networks known about	None	0 (0)	0 (0)	1 (33.3)
	1 – 4	1 (5.9)	11 (100)	0 (0)
	5 – 8	15 (88.2)	0 (0)	1 (33.3)
	9 – 12	1 (5.9)	0 (0)	1 (33.3)
Number of SU services / networks known about	None	2 (11.8)	3 (27.3)	1 (33.3)
	1 – 2	5 (29.4)	7 (63.6)	0 (0)
	3 – 4	8 (47)	1 (9.1)	2 (66.7)
	5 - 6	2 (11. 8)	0 (0)	0 (0)
Number of MH services / networks known about	None	2 (11.8)	0 (0)	1 (33.3)
	1 – 2	3 (17.6)	9 (81.8)	1 (33.3)
	3 – 4	12 (70.6)	1 (9.1)	1 (33.3)
	5 - 6	0 (0)	1 (9.1)	0 (0)

Appendix 5 – Findings from the referral pathways data collection

Please note all figures presented in this appendix are numbers, no percentages are given as the figures are so small.

Table 5.1. Point of contact when disclosure is made

		Point of Disclosure							
		Didn't answer	On Referral	Initial assessment	Follow-up appointment	3 month review	6 month review	Case closure	Other
Bristol	VAW	0	25	14	6	1	0	0	1
	MH	6	0	1	11	1	0	0	0
	SU	0	0	1	8	0	0	0	0
Hounslow	VAW	0	2	0	0	1	1	0	0
	SU	0	0	11	0	0	0	0	0
Nottingham	VAW	1	9	16	11	3	3	0	0
	SU	1	11	15	7	2	0	1	1

Table 5.2. Issue(s) the client presented with that required referral

		Issue					
		Didn't answer	Domestic Violence	Sexual Violence	Mental Health	Substance Use	Domestic Violence & Substance Use
Bristol	VAW	0	0	7	21	19	0
	MH	0	6	7	4	2	0
	SU	0	6	3	0	0	2
Hounslow	VAW	0	0	0	3	1	0
	SU	3	6	0	0	0	0
Nottingham	VAW	4	2	4	26	7	0
	SU	0	23	8	7	0	2

Table 5.3. Action taken by the staff member

		Action Taken						
		Didn't answer	None (Client already engaged with relevant service)	None (client does not want referral to be made)	Signposting (information given to client)	Client supported to make self-referral	Referral made on behalf of client	Other
Bristol	VAW	0	20	13	2	3	8	1
	MH	5	0	2	4	2	4	2
	SU	0	1	3	0	4	1	0
Hounslow	VAW	0	2	0	0	0	2	0
	SU	3	0	0	0	0	2	6
Nottingham	VAW	0	16	3	4	10	9	1
	SU	0	7	9	9	0	4	9

Table 5.4. Agencies and individuals organisations in each area referred clients to for each issue

Nottingham VAW Agencies		
MH Issues	VAW Issues	SU Issues
Women's Centre Counselling GP Counselling Heathcote St NHS MH Team NHS Crisis Team Mandala Centre Amber Valley Recover and Crisis Team Psychiatrist	Topaz Rape Crisis Shine Women's Aid	John Storer Direct Access GP GU Clinic Double Impact
Nottingham SU Agencies		
MH Issues	VAW Issues	SU Issues
Oxford Corner MH Team Dual Diagnosis IAPT	Women's Centre Women's Aid SHE ISAS Mansfield Mediation	

Hounslow VAW Agencies		
MH Issues	VAW Issues	SU Issues
Anchor Counselling Kingston Women's Centre Women's Trust		The Priory Group Kingston Women's Centre
Hounslow SU Agencies		
MH Issues	VAW Issues	SU Issues
	MARAC Social Services	
Bristol VAW Agencies		
MH Issues	VAW Issues	SU Issues
Missing Link	ISVA	SWAN Project ARA BDP
Bristol SU Agencies		
MH Issues	VAW Issues	SU Issues
	Akousis Touchstone The Green House Next Link Attempted Freedom Programme Wish MARAC Police	
Bristol MH Agencies		
MH Issues	VAW Issues	SU Issues
AWP Adult Social Care Second Step Police Safeguarding Adults	Safeguarding Adults Greenhouse GP Next Link Police Social Services Nalaari	DART Police BDP

Table 5.5. Reasons given by clients for not engaging after first referral

		Reasons for not engaging after first contact				
		Question was not Relevant	Following initial assessment, agency state they were unable to meet client's need (e.g. do not provide appropriate service or support needs too high)	Client reported agency or support available to did not meet their needs	Client reported they did not feel able to take up support (e.g. not right time or other personal reasons	Other
Bristol	VAW	45	0	1	1	0
	MH	12	0	1	5	1
	SU	7	0	0	1	1
Hounslow	VAW	4	0	0	0	0
	SU	11	0	0	0	0
Nottingham	VAW	43	0	0	0	0
	SU	37	1	0	0	0

Appendix 6 - Where staff recorded information about MH, SU and VAW

Table 6.1. How staff record information about VAW, SU and MH in Nottingham

		How record VAW					
		Didn't answer n (%)	*Don't have facility but would like to n (%)*	*Would never record it n (%)*	*Put as an 'additional information' note on her record n (%)*	*Record in a specific section of her records n (%)*	*Other n (%)*
Organisation	VAW	5 (29.4)	1 (5.9)	0 (0)	4 (23.5)	7 (41.2)	0 (0)
	MH	4 (20.0)	0 (0)	1 (5)	5 (25)	8 (40)	2 (10)
	SU	1 (12.5)	0 (0)	0 (0)	3 (37.5)	2 (50)	0 (0)
		How record SU					
Organisation	VAW	5 (29.4)	1 (5.9)	0 (0)	4 (23.5)	7 (41.2)	0 (0)
	MH	4 (20.0)	0 (0)	1 (5)	4 (20)	9 (45)	2 (10)
	SU	1 (12.5)	0 (0)	0 (0)	0 (0)	7 (87.5)	0 (0)
		How record MH					
Organisation	VAW	5 (29.4)	1 (5.9)	0 (0)	4 (23.5)	7 (41.2)	0 (0)
	MH	5 (25)	0 (0)	1 (5)	2 (10)	11 (55)	1 (5)
	SU	1 (12.5)	0 (0)	0 (0)	3 (37.5)	4 (50)	0 (0)

Table 6.2. How staff record information about VAW, SU and MH in Bristol

		How record VAW					
		Didn't answer n (%)	*Don't have facility but would like to n (%)*	*Would never record it n (%)*	*Put as an 'additional information' note on her record n (%)*	*Record in a specific section of her records n (%)*	*Other n (%)*
Organisation	VAW	0 (0)	0 (0)	0 (0)	0 (0)	5 (83.3)	1 (16.7)
	MH	1 (25)	0 (0)	0 (0)	0 (0)	2 (50)	1 (25)
	SU	3 (11.5)	2 (7.7)	0 (0)	9 (34.6)	8 (30.8)	4 (15.4)
		How record SU					
Organisation	VAW	0 (0)	0 (0)	0 (0)	2 (33.3)	4 (66.7)	0 (0)
	MH	1 (25)	0 (0)	0 (0)	0 (0)	2 (50)	1 (25)
	SU	4 (15.4)	1 (3.8)	0 (0)	5 (19.2)	12 (46.2)	4 (15.4)
		How record MH					
Organisation	VAW	0 (0)	0 (0)	0 (0)	2 (33.3)	4 (66.7)	0 (0)
	MH	1 (25)	0 (0)	0 (0)	1 (25)	2 (50)	0 (0)
	SU	3 (11.5)	1 (3.8)	0 (0)	8 (30.8)	10 (38.5)	4 (15.4)

Table 6.3. How staff record information about VAW, SU and MH in Hounslow

		How record VAW					
		Didn't answer n (%)	*Don't have facility but would like to n (%)*	*Would never record it n (%)*	*Put as an 'additional information' note on her record n (%)*	*Record in a specific section of her records n (%)*	*Other n (%)*
Organisation	VAW	0 (0)	0 (0)	0 (0)	0 (0)	16 (94.1)	1 (5.9)
	MH	3 (27.3)	0 (0)	0 (0)	0 (0)	3 (27.3)	5 (45.5)
	SU	1 (33.3)	0 (0)	0 (0)	0 (0)	2 (66.7)	0 (0)
		How record SU					
Organisation	VAW	2 (11.8)	0 (0)	0 (0)	1 (5.9)	13 (76.5)	1 (5.9)
	MH	3 (27.3)	0 (0)	0 (0)	0 (0)	3 (27.3)	5 (45.5)
	SU	1 (33.3)	0 (0)	0 (0)	0 (0)	2 (66.7)	0 (0)
		How record MH					
Organisation	VAW	0 (0)	0 (0)	0 (0)	1 (5.9)	15 (88.2)	1 (5.9)
	MH	3 (27.3)	0 (0)	0 (0)	0 (0)	4 (36.4)	4 (36.4)
	SU	1 (33.3)	0 (0)	0 (0)	0 (0)	2 (66.7)	0 (0)

Appendix 7 - Sharing information within and between organisations in the three areas

Table 7.1. Sharing information about clients within and between organisation in Nottingham

VAW Issues		Within your organisation					With other organisations					
		Didn't Answer n (%)	*Yes, always n (%)*	*Yes, depends client/ situation n (%)*	*No, never n (%)*	*Other n (%)*	*Didn't answer n (%)*	*Yes, always n (%)*	*Yes, depends client/ situation n (%)*	*Yes, depends on org n (%)*	*No, never n (%)*	*Other n (%)*
Organisation	VAW	5 (29.4)	3 (17.6)	9 (52.9)	0 (0)	0 (0)	5 (29.4)	0 (0)	9 (52.9)	2 (11.8)	1 (5.9)	0 (0)
	MH	2 (10)	11 (55)	4 (20)	3 (15)	0 (0)	3 (15)	5 (25)	8 (40)	2 (10)	2 (10)	0 (0)
	SU	1 (12.5)	5 (62.5)	2 (25)	0 (0)	0 (0)	1 (12.5)	0 (0)	5 (62.5)	2 (25)	0 (0)	0 (0)
SU Issues												
Organisation	VAW	5 (29.4)	2 (11.8)	10 (58.8)	0 (0)	0 (0)	5 (29.4)	0 (0)	9 (52.9)	2 (11.8)	1 (5.9)	0 (0)
	MH	3 (15)	7 (35)	8 (40)	2 (10)	0 (0)	4 (20)	2 (10)	10 (50)	1 (5)	3 (15)	0 (0)
	SU	1 (12.5)	5 (62.5)	2 (25)	0 (0)	0 (0)	12.5	12.5	62.5	12.5	0 (0)	0 (0)
MH Issues												
Organisation	VAW	5 (29.4)	3 (17.6)	9 (52.9)	0 (0)	0 (0)	5 (29.4)	0 (0)	10 (58.8)	2 (11.8)	0 (0)	0 (0)
	MH	3 (15)	12 (60)	3 (15)	2 (10)	0 (0)	3 (15)	3 (15)	9 (45)	4 (20)	1 (5)	0 (0)
	SU	1 (12.5)	4 (50)	3 (37.5)	0 (0)	0 (0)	1 (12.5)	1 (12.5)	5 (62.5)	0 (0)	0 (0)	1 (12.5)

Table 7.2. Sharing information about clients within and between organisation in Bristol

VAW Issues		Within your organisation					With other organisations					
		Didn't Answer n (%)	*Yes, always n (%)*	*Yes, depends client/ situation n (%)*	*No, never n (%)*	*Other n (%)*	*Didn't answer n (%)*	*Yes, always n (%)*	*Yes, depends client/ situation n (%)*	*Yes, depends on org n (%)*	*No, never n (%)*	*Other n (%)*
Organisation	VAW	0 (0)	3 (50)	3 (50)	0 (0)	0 (0)	0 (0)	0 (0)	4 (66.7)	1 (16.7)	1 (16.7)	0 (0)
	MH	0 (0)	2 (50)	0 (0)	0 (0)	2 (50)	0 (0)	0 (0)	3 (75)	0 (0)	1 (25)	0 (0)
	SU	0 (0)	13 (50)	13 (50)	0 (0)	0 (0)	0 (0)	0 (0)	16 (61.5)	6 (23.1)	4 (15.4)	0 (0)
SU Issues												
Organisation	VAW	0 (0)	2 (33.3)	4 (66.7)	0 (0)	0 (0)	0 (0)	0 (0)	5 (83.3)	1 (16.7)	0 (0)	0 (0)
	MH	0 (0)	0 (0)	3 (75)	0 (0)	1 (25)	0 (0)	0 (0)	3 (75)	0 (0)	1 (25)	0 (0)
	SU	0 (0)	20 (76.9)	6 (23.1)	0 (0)	0 (0)	1 (3.8)	1 (3.8)	20 (76.9)	4 (15.4)	0 (0)	0 (0)
MH Issues												
Organisation	VAW	0 (0)	2 (33.3)	4 (66.7)	0 (0)	0 (0)	1 (16.7)	0 (0)	4 (66.7)	1 (16.7)	0 (0)	0 (0)
	MH	0 (0)	1 (25)	2 (50)	0 (0)	1 (25)	0 (0)	0 (0)	3 (75)	0 (0)	1 (25)	0 (0)
	SU	0 (0)	6 (23.1)	19 (73.1)	1 (3.8)	0 (0)	7 (26.9)	0 (0)	16 (61.5)	2 (7.7)	1 (3.8)	0 (0)

Table 7.3. Sharing information about clients within and between organisation in Hounslow

VAW Issues		Within your organisation					With other organisations					
		Didn't Answer n (%)	*Yes, always n (%)*	*Yes, depends client/ situation n (%)*	*No, never n (%)*	*Other n (%)*	*Didn't answer n (%)*	*Yes, always n (%)*	*Yes, depends client/ situation n (%)*	*Yes, depends on org n (%)*	*No, never n (%)*	*Other n (%)*
Organisation	VAW	0 (0)	3 (17.6)	13 (76.5)	0 (0)	1 (5.9)	0 (0)	0 (0)	13 (76.5)	3 (17.6)	0 (0)	1 (5.9)
	MH	3 (27.3)	3 (27.3)	5 (45.5)	0 (0)	0 (0)	4 (36.4)	0 (0)	3 (27.3)	3 (27.3)	0 (0)	1 (9.1)
	SU	1 (33.3)	1 (33.3)	1 (33.3)	0 (0)	0 (0)	1 (33.3)	0 (0)	0 (0)	2 (66.7)	0 (0)	0 (0)
SU Issues												
Organisation	VAW	0 (0)	2 (11.8)	14 (82.4)	0 (0)	1 (5.9)	0 (0)	0 (0)	14 (82.4)	3 (17.6)	0 (0)	0 (0)
	MH	4 (36.4)	1 (9.1)	6 (54.5)	0 (0)	0 (0)	4 (36.4)	0 (0)	4 (36.4)	2 (18.2)	0 (0)	1 (9.1)
	SU	1 (33.3)	1 (33.3)	1 (33.3)	0 (0)	0 (0)	1 (33.3)	0 (0)	1 (33.3)	1(33.3)	0 (0)	0 (0)
MH Issues												
Organisation	VAW	0 (0)	2 (11.8)	14 (82.4)	0 (0)	1 (5.9)	8 (47.1)	0 (0)	3 (17.6)	5 (29.4)	0 (0)	1 (5.9)
	MH	3 (27.3)	3 (27.3)	5 (45.5)	0 (0)	0 (0)	3 (27.3)	0 (0)	4 (36.4)	3 (27.3)	0 (0)	1 (9.1)
	SU	1 (33.3)	1 (33.3)	1 (33.3)	0 (0)	0 (0)	1 (33.3)	0 (0)	0 (0)	2 (66.7)	0 (0)	0 (0)